***Whom may we thank for referring you to this office? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

**APPLICATION FOR CARE AT ANCHORED CHIROPRACTIC**

Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_HRN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PATIENT DEMOGRAPHICS**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth Date: \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_ Age: \_\_\_\_\_\_\_ 🞏 Male 🞏 Female

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_

E-mail Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone Provider:\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have Insurance: **🞎** Yes **🞎** No Is your insurance provided through a family member? **🞎** Yes **🞎** No

 If yes, what is their Birth Date? \_\_\_\_-\_\_\_\_-\_\_\_\_ Marital Status: **🞎** Single **🞎** Married Driver’s License #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Spouse’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Spouse’s Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Number of children and ages: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name & Number of Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HISTORY of COMPLAINT**

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 **zero** being no pain, rate your above complaints by ***circling the number*:**

**Primary** or chief complaint is: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

**Second** 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? 🞏 It is constant **OR** 🞏 I experience it on and off during the day **OR** 🞏 It comes and goes throughout the week

How did the injury happen? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Condition(s) ever been treated by anyone in the past? 🞏No 🞏 Yes **If yes,** when: \_\_\_\_\_\_ by whom? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How long were you under care: \_\_\_\_\_\_\_\_\_\_\_\_ What were the results? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Previous Chiropractor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **🞎 N/A**

**PLEASE MARK** the areas on the Diagram with the following **letters** to describe your symptoms:

 **R = R**adiating **B** **= B**urning **D =** **D**ull **A =** Aching **N = N**umbness **S = S**harp/**S**tabbing **T = T**ingling

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 a similar problem 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 whoprovided it: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **How long ago? \_\_\_\_\_\_\_**What were the results. 🞏 Favorable 🞏 Unfavorable🡪 please explain. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please identify any and all types of jobs you have had in the past that have 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 in the ***Past*, C** for ***Currently*** have or **N** for ***Never*** have had**:**

\_**\_\_** Broken Bone \_**\_\_**Dislocations **\_\_\_** Tumors \_**\_\_**Rheumatoid Arthritis \_\_\_Fracture **\_\_\_**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 WHOM** |
| **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 Regime:** How does your present problem affect? (See ADL form)

**FAMILY HISTORY**:

**1.** Does anyone in your family suffer with the same condition(s)? 🞎 No 🞎 Yes

 **If yes whom**: 🞎 grandmother 🞎 grandfather 🞎 mother 🞎 father 🞎 sister(s) 🞎 brother(s) 🞎 son(s) 🞎 daughter(s)

 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I hereby authorize payment to be made directly to Anchored Chiropractic for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Anchored Chiropractic for any and all services I receive at this office.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**Patient or Authorized Person’s Signature Date Completed**

**ACTIVITIES OF LIFE**

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

**\_\_\_\_\_**ACTIVITIES: EFFECT:

Carry Children/Groceries 🞏 No Effect 🞏 Painful (can do) 🞏 Painful (limits) 🞏 Unable to Perform

Sit to Stand 🞏 No Effect 🞏 Painful (can do) 🞏 Painful (limits) 🞏 Unable to Perform

Climb Stairs 🞏 No Effect 🞏 Painful (can do) 🞏 Painful (limits) 🞏 Unable to Perform

Pet Care 🞏 No Effect 🞏 Painful (can do) 🞏 Painful (limits) 🞏 Unable to Perform

Extended Computer Use 🞏 No Effect 🞏 Painful (can do) 🞏 Painful (limits) 🞏 Unable to Perform

Lift Children/Groceries 🞏 No Effect 🞏 Painful (can do) 🞏 Painful (limits) 🞏 Unable to Perform

Read/Concentrate 🞏 No Effect 🞏 Painful (can do) 🞏 Painful (limits) 🞏 Unable to Perform

Getting Dressed 🞏 No Effect 🞏 Painful (can do) 🞏 Painful (limits) 🞏 Unable to Perform

Shaving 🞏 No Effect 🞏 Painful (can do) 🞏 Painful (limits) 🞏 Unable to Perform

Sleep 🞏 No Effect 🞏 Painful (can do) 🞏 Painful (limits) 🞏 Unable to Perform

Static Sitting 🞏 No Effect 🞏 Painful (can do) 🞏 Painful (limits) 🞏 Unable to Perform

Static Standing 🞏 No Effect 🞏 Painful (can do) 🞏 Painful (limits) 🞏 Unable to Perform

Yard work 🞏 No Effect 🞏 Painful (can do) 🞏 Painful (limits) 🞏 Unable to Perform

Walking 🞏 No Effect 🞏 Painful (can do) 🞏 Painful (limits) 🞏 Unable to Perform

Washing/Bathing🞏 No Effect 🞏 Painful (can do) 🞏 Painful (limits) 🞏 Unable to Perform

Sweeping/Vacuuming 🞏 No Effect 🞏 Painful (can do) 🞏 Painful (limits) 🞏 Unable to Perform

Dishes 🞏 No Effect 🞏 Painful (can do) 🞏 Painful (limits) 🞏 Unable to Perform

Laundry 🞏 No Effect 🞏 Painful (can do) 🞏 Painful (limits) 🞏 Unable to Perform

Garbage 🞏 No Effect 🞏 Painful (can do) 🞏 Painful (limits 🞏 Unable to Perform

Driving 🞏 No Effect 🞏 Painful (can do) 🞏 Painful (limits) 🞏 Unable to Perform

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_ 🞏 No Effect 🞏 Painful (can do) 🞏 Painful (limits) 🞏 Unable to Perform

**List Prescription & Non-Prescription drugs you take: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s Date: \_\_\_/\_\_\_/\_\_\_**

Please mark **P** for in the **Past, C** for **Currently** have,or **N** for **Never**

\_\_\_ Headache \_\_\_ Pregnant (Now) \_\_\_ Dizziness \_\_\_ Prostate Problems \_\_\_ Ulcers

\_\_\_ Neck Pain \_\_\_ Frequent Colds/Flu \_\_\_ Loss of Balance \_\_\_ Impotence/Sexual Dysfun. \_\_\_ Heartburn

\_\_\_ Jaw Pain, TMJ \_\_\_ Convulsions/Epilepsy \_\_\_ Fainting \_\_\_ Digestive Problems \_\_\_ Heart Problem

\_\_\_ Shoulder Pain \_\_\_ Tremors \_\_\_ Double Vision \_\_\_ Colon Trouble \_\_\_ High Blood Pressure

\_\_\_ Upper Back Pain \_\_\_ Chest Pain \_\_\_ Blurred Vision \_\_\_ Diarrhea/Constipation \_\_\_ Low Blood Pressure

\_\_\_ Mid Back Pain \_\_\_ Pain w/Cough/Sneeze \_\_\_ Ringing in Ears \_\_\_ Menopausal Problems \_\_\_ Asthma

\_\_\_ Low Back Pain \_\_\_ Foot or Knee Problems \_\_\_ Hearing Loss \_\_\_ Menstrual Problem \_\_\_ Difficulty Breathing

\_\_\_ Hip Pain \_\_\_ Sinus/Drainage Problem \_\_\_ Depression \_\_\_ PMS \_\_\_ Lung Problems

\_\_\_ Back Curvature \_\_\_ Swollen/Painful Joints \_\_\_ Irritable \_\_\_ Bed Wetting \_\_\_ Kidney Trouble

\_\_\_ Scoliosis \_\_\_ Skin Problems \_\_\_ Mood Changes \_\_\_ Learning Disabilty \_\_\_ Gall Bladder Trouble

\_\_\_ Numb/Tingling arms, hands, fingers \_\_\_ ADD/ADHD \_\_\_ Eating Disorder \_\_\_ Liver Trouble

\_\_\_ Numb/Tingling legs, feet, toes \_\_\_ Allergies \_\_\_ Trouble Sleeping \_\_\_ Hepatitis (A,B,C)

**Please read carefully**:

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

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

**Example**:

Low Back

Neck

Headache

**No pain** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **worst possible pain**

 **0 1 2 3 4 5 6 7 8 9 10**

1 – What is your pain RIGHT NOW?

**No pain** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **worst possible pain**

 **0 1 2 3 4 5 6 7 8 9 10**

2 – What is your TYPICAL or AVERAGE pain?

**No pain** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **worst possible pain**

 **0 1 2 3 4 5 6 7 8 9 10**

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

**No pain** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **worst possible pain**

 **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 possible pain**

 **0 1 2 3 4 5 6 7 8 9 10**

Informed Consent

**REGARDING:** Chiropractic Adjustments, Modalities, and Therapeutic Procedures:

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risk are most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.

Treatment objectives as well as the risks associated with chiropractic adjustments and, all other procedures provided at Anchored Chiropractic have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_/\_\_\_\_/\_\_\_\_

Patient or Authorized Person’s Signature Date

**REGARDING:** X-rays/Imaging Studies

### I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_/\_\_\_\_/\_\_\_\_

Patient orAuthorized Person’s Signature Date

**FEMALES ONLY 🡪** *please read carefully and check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our receptionist for further explanation.*

🞏 The first day of my last menstrual cycle was on \_\_\_\_-\_\_\_\_-\_\_\_\_ (Date)

### 🞏 I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_/\_\_\_\_/\_\_\_\_

Patient orAuthorized Person’s Signature Date

**ANCHORED CHIROPRACTIC 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 **P**ersonal **H**ealth **I**nformation. In addition we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances 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. If you would like a more detailed explanation, one will be provided to you. In addition, you will find we have placed several copies in report folders labeled **‘HIPAA’** on tables in the reception. Once you have read this notice, please sign the last page, and return only the signature page (page 2) to our front desk receptionist. Keep this page for your records.

**PERMITTED DISCLOSURES:**

1. Treatment purposes - discussion with other health care 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 - in order 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, prisoner 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 would 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 timely 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.

**COMPLAINTS:**

If you wish to make a formal complaint about how we handle your health information, please call Dr. Blake Baggett at (205) 523-4651 If he is unavailable, you may make an appointment with our receptionist to see her within 72 hours or 3 working days. If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to:

DHHS, Office of Civil Rights

200 Independence Ave. SW

Room 509F HHH Building

Washington DC 20201

*Patient initials:* **\_\_\_\_\_\_\_\_\_**

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***ANCHORED CHIROPRACTIC NOTICE REGARDING YOUR RIGHT TO PRIVACY continued…***

I have received a copy of Anchored Chiropractic 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 and several copies kept in the reception area. At this time, I do not have any questions regarding my rights or any of the information I have received.

Patient’s Name DOB HR#

Patient’s Signature Date

Witness Date

**Page 2 of 2**