PATIENT DEMOGRAPHIC FORM

Patient name: _____ Date of birth: _____ Marital Status: S M D

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

Phone Numbers: Primary _____ Secondary _____

Email address:_____

Emergency contact: _____ Phone: _____

Who can we thank for referring you
(circle)? Physician Friend/family Web Other: _____

Is this related to a motor vehicle accident? YES NO If yes, please complete the following:

Name of Insurance Company:_____

Date of Accident:_____Claim Number:_____

Attorney Name_____Phone Number:_____

Is this related to work: YES NO If yes, please complete the following:

Date of injury:_____ Have you filed for worker's compensation YES NO

Claim Number_____

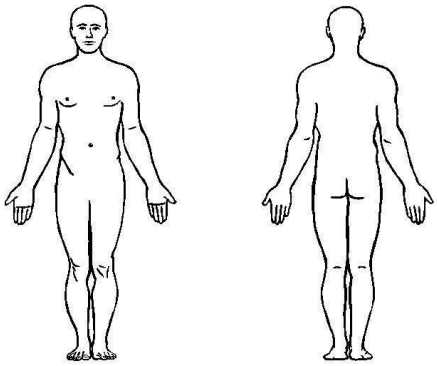
Name of employer: _____ Phone number:
_____

Name of employer contact:_____ Phone number:_____

Name of Case Manager: _____ Phone number: _____

Are you off of work due to this injury? YES NO If off work, how long: _____

Please circle the areas on the right figures where you experience pain.



Circle the severity: 1 = No pain to 10 = Very Severe Pain

Minimal **Severe**

1 2 3 4 5 6 7 8 9 10

1. When did your symptoms begin? _____
2. Has your condition: Improved?_____ Gotten Worse?____ Stayed the same since onset ?_____
3. Circle the things that make your problems worse:

   Bending - Lying - Walking - Standing - Sitting - Movement - Twisting - Lifting

4. Have you ever been treated for this before? YES NO How long ago? _____
5. What treatment did you receive? _____
6. Results of previous treatment? Good _____ Poor _____ Comments _____
7. Approximate date of last Chiropractic treatment? _____
8. List any other major injuries/surgeries you have had other than mentioned above:

_____

9. Current medications/ supplements you're currently taking:

_____

10. Have you had any diseases, major illness, or injuries not indicated on this form either in the past or present? YES NO If yes, please explain _____

_____

I certify that the above information is accurate to the best of my knowledge.

Patient/ Guardian Signature _____ Date: _____

Patient Signature _____ Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, acknowledge that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

• Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
• Obtain payment from third-party payers.
• Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change it Notice of Privacy practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Private Practices.

I understand that I may request in writing that you restrict how my private information is used or Disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Signature _____

Print Name _____Date_____

OneSource
WELLNESS & CHIROPRACTIC

Informed Consent

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. If there is anything unclear to you, please ask the doctor before signing.

The nature of a chiropractic adjustment:
The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use this 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. This may cause an audible "pop" or "click", much like the sound you experience when cracking your knuckles. You may also feel a sense of movement.

Analysis/Examination/Treatment:
As part of the analysis, examination, and treatment you are consenting to the following procedures: basic neurological testing, range of motion testing, muscle strength testing, orthopedic testing, posture analysis, mechanical traction, palpation, hot/cold therapy, electrical stimulation, and spinal manipulative therapy.

The material risks inherent in chiropractic adjustment:
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: cerebral infarction or transient ischemic attack, dislocations, muscle strain, costovertebral strains and separations, and burns. Some patients may experience stiffness and soreness following their first few treatments. As your chiropractor, I will make every reasonable effort during the consult and examination to screen for contraindication to care. However, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me. Fractures are a rare occurrence and generally result from some underlying weakness of the bone; in which I check for during the taking of your health history, any medical reports you may provide me with, and the examination. The complications are generally considered rare.

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

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE

I have read the above explanation of the chiropractic adjustment and related treatment. By signing below I state that I have weighed the risks involved in undergoing chiropractic 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 treatment.

Patient's Name _____ Patient's Signature _____

Date _____ Signature of parent or guardian (if a minor) _____