Arctic Chiropractic Intake Form

Date:

Name: _____ **D.O.B.:** _____ (mm/dd/yy) **SNN:** _____

Mailing Address: _____
Street City/Town State Zip code

Phone: _____
Home/Cell # Work #

Gender: □ **Male** □ **Female**

Email: _____

Marital Status: S | M | W | D | Other

Employer: _____ **Occupation:** _____

Are you currently involved in a workman's compensation or litigation/claim involving an injury? □ Yes □ No

Emergency Contact: _____
Name Relationship Phone #

How did you hear about us? □ **Friend** □ **Student** □ **Co-Worker** □ **Family** □ **Website** □ **Advertising** □ **Other:** _____

Patient information contained within this form is considered strictly confidential. Your responses are important to help us better understand the health issues you face and ensure the delivery of the best possible treatment.

Please check ☑ if any of the following apply to you:

General
- □ Allergies
- □ Depression
- □ Dizziness
- □ Fainting
- □ Fatigue
- □ Headaches
- □ Loss of sleep
- □ Nervousness
- □ Weight loss/gain

Muscle/ Joint
- □ Arthritis/rheumatism
- □ Muscle weakness
- □ Low back pain
- □ Neck pain
- □ Mid back pain
- □ Joint pain

Genitourinary
- □ Bladder infection
- □ Prostate trouble

Gastrointestinal
- □ Abdominal pain
- □ Constipation
- □ Diarrhea
- □ Difficult digestion
- □ Bloated abdomen
- □ Hernia

Skin
- □ Bruise Easily
- □ Dryness
- □ Hives
- □ Rash
- □ Varicose veins
- □ Psoriasis

Respiratory
- □ Chest pain
- □ Chronic cough
- □ Difficulty breathing
- □ Hay fever

Cardiovascular
- □ High/Low blood pressure
- □ Hardening of the arteries
- □ Irregular pulse
- □ Poor circulation
- □ Rapid heartbeat
- □ Swelling of ankles

Women only
- □ Hot flashes
- □ Lumps in breast
- □ Menopause

Are you pregnant?
□ Yes □ No

If yes, how many months?
_____

How many children do you have?
_____

Check any of the conditions you have or have had:
- □ Anemia
- □ Appendicitis
- □ Arteriosclerosis
- □ Asthma
- □ Bronchitis
- □ Cancer
- □ Diabetes
- □ Eczema
- □ Emphysema
- □ Epilepsy
- □ Fibromyalgia
- □ Heart burn
- □ Heart disease
- □ HIV/AIDS
- □ Multiple Sclerosis
- □ Numbness/tingling
- □ Pacemaker
- □ Osteoporosis
- □ Pneumonia
- □ Rheumatic fever
- □ Stroke
- □ Thyroid disease

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Give a brief detailed description of the problem you are currently experiencing: _____

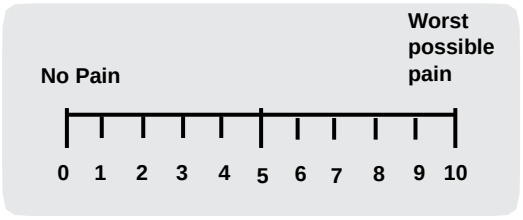
_____

_____

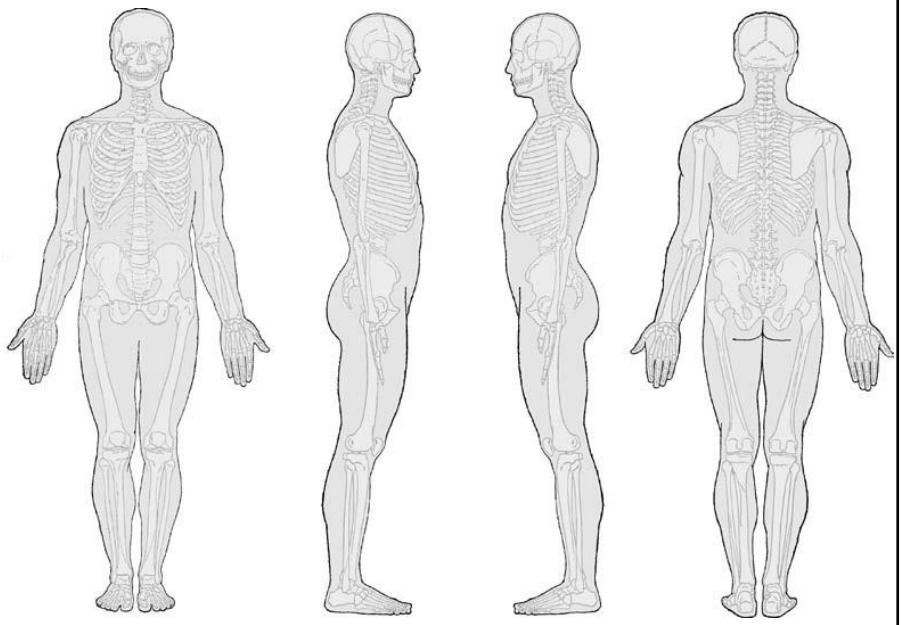
_____

- How long have you had this condition? _____ Is it getting worse? □ Yes, □ No_____
- Which activities are affected? □ work, □ sleep, □ sitting, □ standing, □ other: _____
- What seemed to be the initial cause: _____

Please place a mark at the level of your pain on the scale below:



Please mark your areas of pain on figure below



Are you currently satisfied with your:

- Physical endurance …. □ Yes □ No
- Physical strength ……. □ Yes □ No
- Flexibility & balance … □ Yes □ No
- Ability to relax? ……..□ Yes □ No

Past Health History

Have you…

- Been hospitalized in the last 5 years.... □ Yes □ No If yes, explain briefly_____
- Had any mental disorders? ……..…..□ Yes □ No If yes, explain briefly _____
- Had any broken bones? ……..... □ Yes □ No If yes, explain briefly_____
- Had any strains or sprains? ……..…..□ Yes □ No If yes, explain briefly_____
- Ever used orthotics? ……. □ Yes □ No If yes, explain briefly _____

Do you exercise regularly? □ Yes □ No _____

How is most of your day spent? □ standing, □ sitting, □ other: _____

How old is your mattress? _____

When was your last physical? _____

Please list any medication you are currently taking and why: _____

_____

_____

_____

Is there anything else your health care provider should know? _____

_____

_____

Arctic Chiropractic Intake Form **Date:**

Arctic Chiropractic Fairbanks

Informed Consent to Chiropractic Treatment

The State of Alaska requires every patient to be informed of the risks of treatment and the alternatives to treatments prior to the beginning of care. The following is Arctic Chiropractic Fairbanks, LLC's informed consent for treatment. We intend this consent form to cover the entire course of treatment for your present condition and for any conditions for which you seek treatment at this clinic.

The nature of chiropractic treatment. The doctor will use his/her hands or a mechanical device to adjust/manipulate your joints. You may hear a "click" or "pop", similar to when a knuckle is "cracked" and you may feel movement of the joint. Various ancillary procedures, such as a hot or cold packs, electric muscle stimulation, therapeutic ultrasound, myofascial therapy, massage, traction as well as exercise instruction may also be used.

Possible risks and probability. There are inherent risks in all treatments derived by any health care provider ranging from taking a single aspirin to a complicated brain surgery. Chiropractic care is no exception. Although we take every precaution, there are indeed some slight risks to chiropractic adjustments/manipulations. The risk is very minor to non-existent in any treatment of the extremities. The risks involved in treatment to the spine excluding the neck are several. A list from the least to the most serious would include muscular strain (rare), ligamentous sprain (rare), fractures (rare), and injury to the intervertebral discs, nerves, or spinal cord (very rare). The risk involved in the treatment of the neck would include any of the preceding list but also include the remote possibility of cerebrovascular injury, or stroke (very rare: incident rate is one in ten million). A minority of patients may notice a stiffness or soreness after the first few days of treatment (common). The ancillary physical therapy procedures could produce skin irritations, burns or other minor complications (rare).

Other treatment options, not provided by this clinic, which could be considered, may include the following:

- Over-the-counter analgesics. The risks of these medications include irritations to the 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 numerous undesirable effects, usually more serious than those listed above and patient dependence in a significant number of cases.
- Surgery in conjunction with medical care adds the risks of adverse reactions to anesthesia (which include death), as well as 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 include chronic pain cycles. It is quite probable the delay of treatment will complicate the condition and make further rehabilitation more difficult.

Concerns or questions. Please ask your doctor. The doctors and the staff at Arctic Chiropractic Fairbanks have gone to great lengths to make your health and safety a top priority. We will be glad to explain any concerns about treatment you may have. Suffice to say we will only recommend treatment for you that we would feel comfortable having performed on ourselves.

I have read the above explanation of chiropractic care. I also had the opportunity to ask questions and have them 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.

Print Patients Name Signature Date

Guardian (if patient is a minor) Signature Date

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Arctic Chiropractic Fairbanks

Consent for Massage Therapy

- The unclothed body will be properly always draped for your warmth, sense of security, and a mark of massage professionalism.
- Forced attention and manual therapy will be given as agreed upon by the therapist and client for the predetermined goals of stress reduction, relief of muscular discomfort, and/or health therapy. I have been given an opportunity to ask questions.
- I as a client to provide complete and accurate health information and notice of health changes at successive appointments as appropriate.
- I understand that massage therapy is designed to be an ancillary health aid and is not primary health care treatment.
- Written referral is requested from your primary care provider if:
    - You are currently receiving care.
    - You have a specific medical condition or symptoms for which you take medication or receive periodic evaluation or treatment.
- I will immediately inform my therapist of any unusual sensation or discomfort, so that the application of pressure or strokes may be adjusted to my level of my comfort.
- I understand that this is a professional massage, is therapeutic in nature and is performed by a trained state-licensed therapist.
- I understand that by signing this form, I give consent to receive the treatment discussed in all future sessions and agree that my presence at subsequent session shall be constructed to validation of this written consent.
- I have read this form and hereby freely give my permission to receive massage therapy.
- **I understand that the massage is not sexually oriented in any way and that any illicit or suggested remarks or behavior on my part will result in immediate termination of the session.**

Massage Cancellation Policy

We understand that unanticipated events happen occasionally in everyone's life. In our desire to be effective and fair to all our patients and out of consideration for therapists' time, we have adopted the following policies due to the limited availability of appointments:

- 24-hour advance notice is required when canceling an appointment. A $50 fee will be applied to your account if an appointment is missed/cancelled and cannot be filled.
  _____ I understand and accept this policy.
- Appointment times have been arranged specifically for you. If you arrive late your session may be shortened to accommodate others whose appointments follow yours. Your therapist can accommodate a maximum of 15 minutes late for your appointment. After that, we will need to reschedule your appointment.

Printed Patient Name Signature Date

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Arctic Chiropractic Fairbanks

Kevin Lewis, D. C.

Insurance:

Primary Insurance: _____ Policy #_____Group#_____

Policyholder's Full Name (The person who holds the policy) _____

Policyholder's Date of Birth: _____/_____/_____ Relationship to Patient: _____

Secondary Insurance: _____ Policy # _____ Group # _____

Tertiary Insurance: _____ Policy # _____ Group # _____

- Notice of Privacy Practice Patient Acknowledgement

I have received and/or reviewed this patient's Notice of Privacy Practices. The notice provides details about uses and disclosures of my protected health information that may be needed by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information. I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices, and to make changes regarding all protected health information resident at or controlled by the practice. I understand that I may obtain this practice's current Notice of Privacy Practices upon request.