Butler Chiropractic & Wellness

Case #: _____

NEW PATIENT INFORMATION

Welcome! Please allow our staff to photocopy your driver's license and insurance card (if applicable).

PLEASE PRINT CLEARLY. **Today's Date: _____**

Full Name: _____ E-mail: _____ Gender: ☐M ☐F Age: ____ Birth Date: _____

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

Social Security#: _____-____-_____ Driver's License #: _____ Home Phone: (___) _____

Marital Status: ☐S ☐M ☐D ☐W # of Children: ___ Work Status: ☐Full time ☐Part-time ☐Retired Cell Phone: (___) _____

Females: Last Menstrual period: ___/___/_____ Pregnant? ☐Y ☐N Nursing? ☐Y ☐N Fax: (___) _____

Employer: _____ Occupation: _____ Work Phone: (___) _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Name of Spouse, Parent or Guardian: _____ Age: ____ Birth Date: _____ SS#: _____-____-_____

Spouse's Employer: _____ Spouse's Occupation: _____ Work Phone: (___) _____

In case of an Emergency Contact: _____ Relationship: _____

Home Phone: (_____) _____ Cell Phone: (_____) _____ Work Phone: (_____) _____

Do you have health insurance? ☐ Yes ☐ No Plan/Group #_____ ☐Insurance Card(s) Copied by Office Staff

Insurance Company _____ ☐Driver's License Copied by Office Staff

How did you hear about our clinic? Who may we thank for referring you? _____

We want you to know how your **Patient Health Information (PHI)** will be used in this office and your rights concerning those records. Before we will begin any health care operations, we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your **PHI,** we encourage you to read the **HIPAA NOTICE** that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow Butler Chiropractic & Wellness to use their Patient Health Information (PHI) for the purpose of treatment, payment, health care options, and coordination of care.
2. The patient has the right to examine and obtain a copy of his/her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, the staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by Butler Chiropractic & Wellness to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment, and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Please continue and sign last page

HEALTH CONCERNS: Please list your top health concerns in order of priority.

1) _____
2) _____
3) _____
4) _____

TREATMENT: What type of treatment are you looking for?

☐ I am looking for the most minimal amount of care to "patch up the symptoms" of my problem.
☐ I am looking to resolve my symptoms and then go on to "fix the cause" of my problem.
☐ I am looking to take care of my problem and then go on to "achieve optimal health and wellness."

COMPLAINT/PROBLEM: In relation to your primary complaint:

When did you first seek treatment for this problem? _____ Has another doctor(s) treated you for this condition? ☐Y ☐N

If yes, whom? _____ Treatment(s): _____

Have you had any intolerance or reactions to treatments? ☐Y ☐N Describe: _____

If this is a recurrence, when was the first time you noticed this problem? _____

How did it originally occur? _____ Has it become worse recently? ☐Y ☐N ☐Same ☐Better ☐Gradually worse

How frequent is the condition? ☐Constant ☐Daily ☐Intermittent ☐Night Only How long does it last? ☐All day ☐Few hours ☐Minutes

Is this condition interfering with your: ☐Work ☐Sleep ☐Daily routine ☐Recreation ☐Other: _____

How long has it been since you really felt good? ☐Days ☐Weeks ☐Months ☐Years ☐> 10 years

Describe the pain: ☐Sharp ☐Dull ☐Numbness ☐Tingling ☐Aching ☐Burning ☐Stabbing ☐Other: _____

What makes the problem worse? ☐Standing ☐Sitting ☐Lying ☐Bending ☐Lifting ☐Twisting ☐Other: _____

Is there anything you can do to relieve the problem? ☐Y ☐N If yes, describe: _____

If no, what have you tried to do that has not helped? _____

What do you believe is wrong with you? _____

Are there any other conditions or symptoms that may be related to your major symptoms? ☐Y ☐N If yes, what? _____

Have you been in an auto accident? ☐Past year ☐Past 5 years ☐Over 5 years ☐Never

Describe: _____

Please check all of the symptoms that apply. (**P**=Past / **C**=Current)

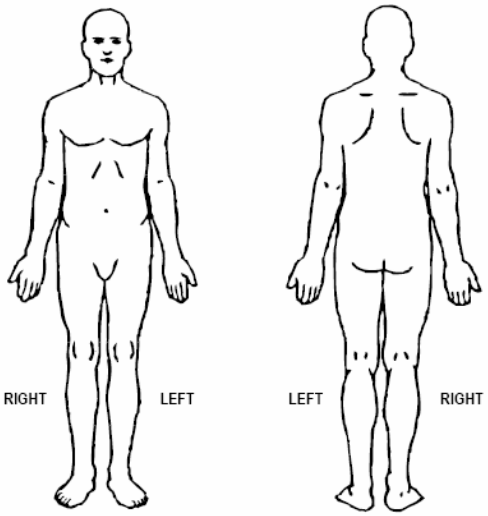
P / C		P / C		P / C	
☐ ☐	Headache	☐ ☐	High Blood Pressure	☐ ☐	Tingling in Feet
☐ ☐	Facial Pain	☐ ☐	Low Blood Pressure	☐ ☐	Walking Problems
☐ ☐	Eye Pain	☐ ☐	Abdominal Pains	☐ ☐	Sore Muscles
☐ ☐	Blurred Vision	☐ ☐	Nausea/Vomiting	☐ ☐	Weak Muscles
☐ ☐	Dizziness	☐ ☐	Poor Appetite	☐ ☐	Paralysis
☐ ☐	Earache	☐ ☐	Fullness of Bladder	☐ ☐	Shakiness
☐ ☐	Forgetfulness	☐ ☐	Urination Difficulty	☐ ☐	Sweating
☐ ☐	Confusion	☐ ☐	Frequent Urination	☐ ☐	Insomnia
☐ ☐	Sinusitis	☐ ☐	Constipation	☐ ☐	Fainting
☐ ☐	Teeth Grinding	☐ ☐	Hemorrhoids	☐ ☐	Convulsions
☐ ☐	Dry Mouth	☐ ☐	Decreased Sex Drive	☐ ☐	Irritability
☐ ☐	Excessive Thirst	☐ ☐	Menstrual Irregularities	☐ ☐	Impatience
☐ ☐	Unpleasant Taste	☐ ☐	Elbow / Hand Pain	☐ ☐	Fatigue
☐ ☐	Neck Pain	☐ ☐	Tingling in Hands	☐ ☐	Feel Loss of Control
☐ ☐	Sore Throat	☐ ☐	Clammy Hands	☐ ☐	Other: _____
☐ ☐	Lump in Throat	☐ ☐	Low Back Pain		_____
☐ ☐	Swallowing Pain	☐ ☐	Hip Pain		
☐ ☐	Unsteady Voice	☐ ☐	Knee Pain		
☐ ☐	Shoulder Pain	☐ ☐	Poor Circulation		
☐ ☐	Persistent Coughing	☐ ☐	Swollen Joints		
☐ ☐	Chest Pressure	☐ ☐	Joint Stiffness		
☐ ☐	Slow Heart Rate	☐ ☐	Swollen Ankles		
☐ ☐	Rapid Heart Rate	☐ ☐	Ankle / Foot Pain		

*__Additional__
(Please check all that apply)

☐ Seizures (Epilepsy)
☐ Transplant
☐ Surgically Implanted Device
☐ Pacemaker

Please use the legend symbols below to accurately mark the areas in which you feel these sensations.

Stabbing/Cutting – |||
Burning – XXX
Numbness – ===
Tingling - :::
Cramping - ^^^
Dull - ###



ALLERGIES: Please check and list all allergies.

☐ Food: _____

☐ Medications: _____

☐ Seasonal / Other: _____

MEDICATIONS: Please check and list all medications that you are currently taking with the date you began taking them.

	Medication Name	Date Started-Date Stopped
☐ Antacids		
☐ Antibiotics		
☐ Antidepressants		
☐ Anti-Diabetics		
☐ Anti-Inflammatory(s)		
☐ Blood Pressure Lowering Meds.		
☐ Cholesterol Lowering Meds.		
☐ Hormone Replacements (HRT)		
☐ Oral Contraceptives		
☐ Other		

SCARS / SURGICAL PROCEDURES: List all scars and surgical procedures you have had: _____

_____

SUPPLEMENTS: Do you take Vitamins/Supplements or Herbs? ☐Y ☐N If yes, who recommended them? _____

HANDEDNESS: ☐ Left ☐ Right ☐ Ambidextrous

HABITS:	Heavy	Moderate	Light	None
Alcohol	☐	☐	☐	☐
Coffee/Tea	☐	☐	☐	☐
Soda / Diet Soda	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Drugs	☐	☐	☐	☐
Stress Level	☐	☐	☐	☐

	5-7x/wk	3-5x/wk	1-3x/wk	None	Type	Duration
Exercise	☐	☐	☐	☐		

	8+ hrs	7-8 hrs	6-7 hrs	5-6 hrs	<5 hrs
Sleep	☐	☐	☐	☐	☐

	5+	4	3	2	1
Meals / Day	☐	☐	☐	☐	☐

	64+ oz	32-64 oz	16-32 oz	8-16 oz	<8 oz
Water / Day	☐	☐	☐	☐	☐

WORK ACTIVITY: ☐ Heavy Labor ☐ Light Labor ☐ Mostly Sitting ☐ Mostly Standing ☐ Walking / Moving ☐ Driving

FAMILY HISTORY: Identify any conditions that you or any of your family members have now or have had in the past:
(**G** = Grandparents, **M** = Mother, **F** = Father, **S** = Siblings, **X** = Self)

____ Alcoholism
____ Anemia
____ Cancer
____ Cold Sores
____ Deep Vein Thrombosis
____ Detached Retina
____ Diabetes
____ Eczema
____ Emphysema
____ Epilepsy
____ Goiter
____ Gout
____ Heart Disease
____ HIV / AIDS
____ Miscarriage(s)
____ Mumps
____ Pleurisy
____ Pneumonia
____ Polio
____ Rheumatic Fever
____ Stroke
____ Tumor(s)
____ Ulcer(s)
Other: _____
_____
_____
_____

CONSENT TO X-RAY

FEMALES:

I understand that if I am pregnant and have X-rays taken which expose my lower torso to radiation, it is possible to injure the fetus. I understand, have been advised, that the ten days following the onset of menstrual period are generally considered to be safe for X-ray examinations. With the full understanding of the above, I do hereby state that, to the best of my knowledge, I am NOT pregnant, nor is pregnancy suspected or confirmed at this time and I wish to have an X-ray examination performed now.

Please continue and sign last page

Additionally, I understand that it is my responsibility to notify the staff or doctor as soon as possible if I do become pregnant in the future, in order to prevent X-ray exposure to the fetus.

Please Initial: ☐ Yes, I understand and I am NOT pregnant ☐ No, I do not understand or I am or may be pregnant

Informed Consent to Chiropractic Care

The nature of the chiropractic adjustment: The doctor will use his/her hands or a mechanical device in order to move your spinal joints. This procedure is called a spinal adjustment and it is intended to reduce spinal subluxation (slight dislocation of the spinal joints). You may feel a "click" or "pop", such as the noise when a knuckle is "cracked", and you may feel movement of the joint. Various ancillary procedures, such as cervical pillow support, cold laser, intersegmental traction or hot or cold packs may also be used.

Possible Risks: As with any health care procedure, complications are possible following a chiropractic adjustment. Fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord are rare occurrences and generally result from some underlying weakness of the bone or surrounding tissues. Usually there is an underlying, pre-existing vascular condition like atherosclerosis that contributes to a stroke resulting after a neck adjustment. A minority of patients may notice stiffness or soreness after the first few days of treatment. We will not accept individuals for treatment unless we feel confident that we can help them.

Probability of risks occurring: The risks of complications due to chiropractic treatment have been described as "rare", about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke, has been estimated at one in one million to one in twenty million, and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered "rare".

Other treatment options which could be considered may include the following:

- *Over-the-counter analgesics* may cause irritation to stomach, liver and kidneys, and other side effects in 1,000 to 4,000 people per one million; and reportedly 16,500 die annually from their use.
- *Medical care,* typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
- *Hospitalization and bed rest* in conjunction with medical care adds risk of exposure to virulent communicable disease, loss of muscle tone and strength at the rate of 4% a day.
- *Surgery* in conjunction with medical care adds the risks of infections, adverse reaction to anesthesia, disfiguring scar as well as an extended convalescent period in a significant number of cases. Serious neurological complications from neck surgery are 15,600 per million; mortality rates are 6,900 per million.

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 induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult. **I have had the following unusual risks of my case explained to me.**

IF YOU AND/OR THE INDIVIDUAL LISTED BELOW UNDERSTAND THE ABOVE INFORMATION, PLEASE SIGN BELOW.

I have read or have had read to me the explanation above of chiropractic care. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the health plan recommended, and hereby give my full consent to treatment.

_____

Patient's Printed Name

_____ _____

Patient's Signature or Signature of Legal Guardian Date