

I have read and agree to the above conditions

Valley Chiropractic

Patient Consent Form

Authorization for Care:

I understand that chiropractic treatment consists of moving joints and soft tissues as well as physical therapy modalities and exercise protocols. Although chiropractic care is considered a safe and effective tool for decreasing pain and improving activities of daily life, I am aware that the benefits are not guaranteed and the following are possible risks:

- Soreness: It is common for people to experience soreness after the first few treatments as the body responds to the new movement and posture.
- Dizziness: Temporary symptoms like dizziness and nausea can occur but are rare.
- Fracture: Patients with weak bones from underlying pathologies may be susceptible to injury.

I understand alternative treatments are available including non-treatment, rest, medication, and surgery, however, these also have associated risks. I have read, or have had read to me, the above consent and have had the opportunity to ask any questions regarding its content.

I, _____, hereby give my consent for chiropractic examination and treatment and authorize procedures as deemed necessary in the diagnosis and/or treatment of my condition.

Signature: _____ Date: _____

Protected Health Information:

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that personal health care information be kept confidential. We understand the importance of your privacy and will do our best to maintain it.

- Only when it is appropriate or necessary, will we provide information regarding treatment, payment, or health care operations to a third party.
- We support your right to inspect and copy your personal medical records upon written request.
- You have the right to refuse consent or request restrictions on certain uses and disclosures of your health information. If you chose to give your consent, you have the right to revoke it, in writing, at any time.
- You have the right to review our Notice of Privacy Practices and speak with our HIPAA Compliance Officer, Serena Young, regarding questions.

I, _____, understand my right according to HIPAA and how my personal health care information may be used and disclosed.

Signature: _____ Date: _____

Welcome to Valley Chiropractic!
Kindly take a moment to familiarize yourself with our office policies and procedures.

Payment Policies and Procedures:

Payment must be made in full at the time services are rendered.

HEALTH INSURANCE: We are an **out of network** provider. As a courtesy, we will gladly submit to your health insurance company for reimbursement to you. Insurance policies can differ greatly in terms of deductible and percentage of coverage. Please contact your insurance company if you have any questions regarding your plan.

PERSONAL INJURY: Depending on your individual circumstance, your auto insurance company may pay us directly for your treatment. If you do not have medical coverage on your car insurance, you will be responsible for payment at the time of service.

Appointments and Scheduling:

We make an extra effort to stay on time and ask that you be on time as well.

A new patient visit is approximately 30 minutes in length and costs **\$165.00**. A routine office visit is 15 minutes in length and costs **\$90.00**.

If you have a new injury while under care, please let us know so we can provide necessary paperwork and schedule accordingly.

Cancellation and Missed Appointment Policy:

If you need to cancel your appointment, please do so **24 hours** prior to the time of the appointment to avoid charge. If you cancel without 24 hours' notice, you will be responsible for the appointment fee. IF you miss your appointment, you will be responsible for the appointment fee.

FINANCIAL RESPONSIBILITY: I understand and agree that I am personally responsible for my account.

We appreciate you greatly as our patient and strive to accomplish wonderful results and success for you.

I have read and understood the patient treatment consent policies of Valley Chiropractic.

Signature

Date

Printed Name

Please mark (x) for all present symptoms and circle (o) all previous symptoms.
Additionally, please circle R for Right and L for Left.

NAME: _____ Height: _____ Weight: _____

HEAD:

- ☐ Headache
- ☐ Light-headedness
- ☐ Loss of balance
- ☐ Ear ache
- ☐ Ringing in ear(s) (R - L)
- ☐ Pain relieves with: _____

NECK:

- ☐ Neck feels out of place
- ☐ Muscle spasms
- ☐ Neck pain with movement
- ☐ Neck pain with rest
- ☐ Pain relieves with: _____

CHEST:

- ☐ Chest pain
- ☐ Shortness of breath
- ☐ Rib pain
- ☐ Breast pain

ARE YOU:

- ☐ Left handed
- ☐ Right handed
- When using a mouse:
 - ☐ Left handed
 - ☐ Right handed

SHOULDERS/ ARMS/ HANDS:

- ☐ Pain in shoulder joint (R - L)
- ☐ Pain between shoulders
- ☐ Can't raise arm
- ☐ Pain in upper arm
- ☐ Pain in elbow
- ☐ Pain in forearm
- ☐ Pain in hand (s)
- ☐ Sensation of pins & needles
- ☐ Numbness
- ☐ Loss of grip strength
- ☐ Pain relieves with: _____

MID-BACK:

- ☐ feels out of place
- ☐ pain with movement: _____

LOW BACK:

- ☐ Low back feels out of place
- ☐ Low back pain with movement
- ☐ Low back pain with rest
- ☐ Muscle spasms
- ☐ Pain relieves with: _____

ABDOMEN:

- ☐ Nervous stomach
- ☐ List foods can't eat _____

HIPS/ LEGS / FEET:

- ☐ Pain in buttock(s) (R - L)
- ☐ Pain in hip joint (R - L)
- ☐ Pain down leg (R - L)
- ☐ Knee pain
- ☐ Pins & needles in leg(s) (R - L)
- ☐ Numbness of leg (R - L)
- ☐ Numbness of foot (R - L)
- ☐ Pain relieves with: _____

WOMEN:

- ☐ Menstrual cramping
- ☐ Irregularity
- ☐ Menopause
- ☐ Hysterectomy
- ☐ Fibroids
- ☐ Breast Implants
- ☐ Pregnant

GENERAL:

- ☐ Change in sleep pattern
- ☐ Gain/loss of weight _____ lbs

DIET:

- ☐ Eat a varied diet
- ☐ Water _____ cups/day
- ☐ Coffee _____ cups/day
- ☐ Tea _____ cups/day
- ☐ _____ caffeinated _____ herbal
- ☐ Alcohol _____ srvgs/day
- ☐ Smoker

EXERCISE:

Type : _____

Frequency: _____

WHAT POSITION DO YOU SLEEP IN?

- ☐ Back
- ☐ Front (Stomach)
- ☐ Side (R - L)

Describe major complaint(s) and symptom(s): _____

Date you first noticed symptom(s): _____

HAVE YOU:

- ☐ Been knocked unconscious?
- ☐ Had a recently fractured bone?
- ☐ Used a crutch or other support?
- ☐ Been in an auto accident? If so, when? _____
- ☐ Had a surgery?
- ☐ Been treated for a spine or nerve disorder?
- ☐ Been hospitalized for other than surgery?

PLEASE LIST:

Medication currently taking: _____
Known allergies: _____
Recent surgeries: _____

MARK (x) THE FOLLOWING CONDITIONS YOU HAVE (OR HAD) and CIRCLE (o) ITEMS THAT ARE COMMON TO OTHER FAMILY MEMBERS:

- ☐ A.I.D.S.
- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Stroke
- ☐ Cancer
- ☐ Heart Disease
- ☐ Smoking

Anything else you want to tell the doctor? _____

After reading and filling out the health history, your signature will verify that all the information you have given us is accurate and that you have read the health history questions entirely.

Signature _____ Date: _____

ACTIVITY QUESTIONNAIRE

Patient Name: _____ Date: _____

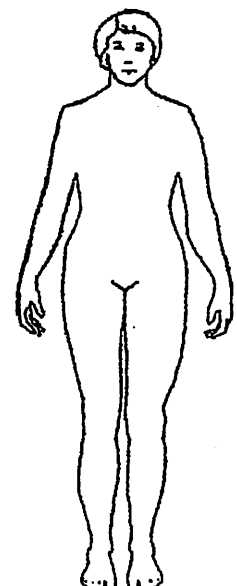
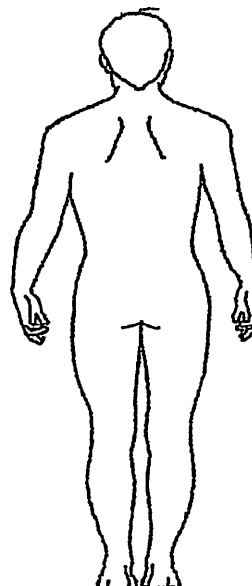
Check only the activities below that affect you currently. Be specific and indicate whether your pain, weakness, stiffness or other symptoms annoy you, slow you down, make it difficult or prevent you from performing the activity.

ACTIVITY DESCRIPTION	ANNOYS ONLY	SLOWS DOWN	HARD TO DO	UNABLE TO DO
Bending head downward or upwards				
Working at computer station				
Driving car				
Sitting				
Working at desk				
Lifting/reaching hands over level of shoulder				
Lifting/reaching hands over level of head				
Lifting at work				
Doing reaching activities				
Combing/brushing hair				
Typing on a keyboard				
Carrying objects in hand				
Gripping objects or using wrists or hands				
Sleeping				
Recreational/sports/hobby activities				
Doing housework or gardening				
Stooping/bending				
Twisting				
Crouching/kneeling				
Walking				
Standing				
Climbing stairs				
Running				
Pushing/pulling				
Lifting at home				
Sexual relations				

PAIN DRAWING

Please indicate below the appropriate location of pain and the symbol that best describes the discomfort you are presently experiencing:

Sharp & Stabbing = + + + +
 Dull & Achy = V V V V
 Pins & Needles = 0 0 0 0
 Numbness = / / / /



(Please click on the images and use the space bar to advance through the diagram) -->