QUALITY CARE
CHIROPRACTIC AND WELLNESS

Patient Information

Full Name: _____ Date: _____
First *M.I.* *Last*

Gender: ☐ Male ☐ Female ☐ Unknown Date of Birth: _____

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Phone: _____ Email _____

Reminder Preference ☐ Phone ☐ Text ☐ Email

Race: _____ Ethnicity: ☐ Caucasian ☐ Hispanic ☐ _____ Language: ☐ English ☐ _____

Primary Care Provider: _____ Vision Impaired? ☐ Yes ☐ No Hearing Impaired? ☐ Yes ☐ No

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Spouse's Name: _____ Spouse's DOB: _____

*Did anyone refer you to our office? ☐ No ☐ Yes — Who may we thank? _____

INSURANCE COVERAGE *Do you have ☐ Insurance ☐ AFLAC ☐ Colonial ☐ Combined ☐ No ☐ Yes
*Is this condition due to an injury from ☐ Work ☐ Vehicle Collision ☐ No ☐ Yes

Please provide a COPY of Insurance Card(s)

Financial Responsibility

I agree to be financially responsible for all charges incurred at this clinic including my insurance deductible, co-payment and any services rejected by my insurance company. I have read all the information on this sheet and have completed the above answers. I certify this information to be true and correct to the best of my knowledge. I will notify you of any changes in my health status or the above information.

_____ _____
Signature/Parent of Minor/Guardian Date

Assignment

I hereby instruct and direct my insurance company to pay by check made out and mailed directly to this clinic the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered by this clinic.

_____ _____
Signature/Parent of Minor/Guardian Date

Minor Consent Form

I, _____, give my permission for Dr. Joshua Thiede D.C. to treat my son/daughter_____. I also agree to X-rays if the Doctor feels they are necessary.

_____
Signature/Parent of Minor/Guardian Date

History

My problem has occurred as a result of:

My symptoms or problem began on:

- ☐ I don't know what could have caused my problem.
- ☐ My problem developed gradually over a period of time.

I have had this problem before (# of times it has occurred):

- ☐ I have not experienced this problem before.

The reason I delayed in seeking care from the time my problem began until now was due to:

Since my injury, I have missed work or school:

- _____ days
- _____ weeks
- _____ months
- _____ years
- ☐ Since the accident

What did you try on your own to help your problem?

- ☐ I didn`t try to help my pain by doing anything on my own (i.e., taking drugs, stretching, heat, etc.).
- ☐ I tried to help my pain by:

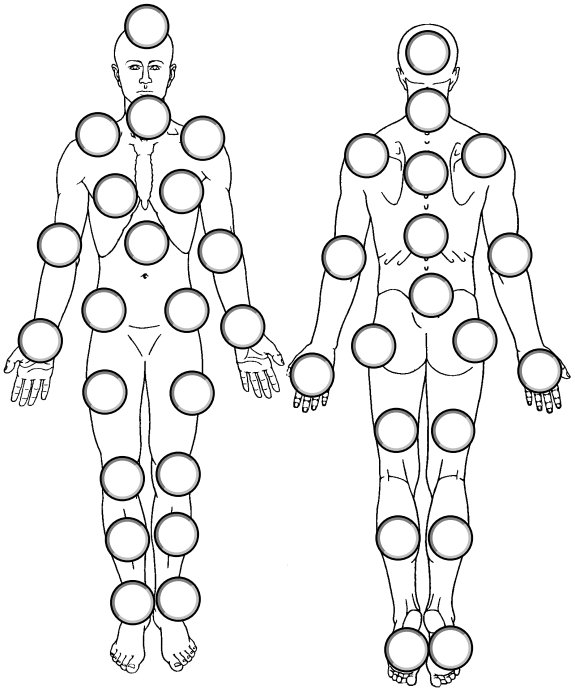
Who are the health care providers you have seen in the past?

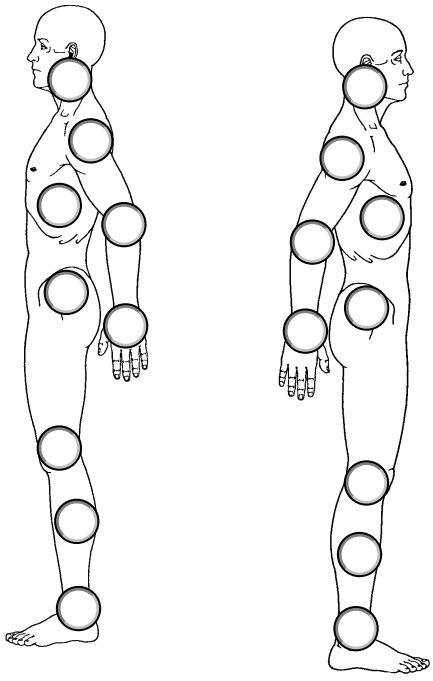
- ☐ I have been to this office in the past for treatment.
- ☐ I have seen a previous healthcare provider for this problem.
- ☐ I have not seen a healthcare provider for this condition.
- ☐ I currently do not have a primary care provider.
- ☐ What are the names of the health care providers you have seen and the dates you saw them last:

I have had the following prior treatment in the past:

- ☐ Past surgery
- ☐ Chiropractic care
- ☐ OTC meds
- ☐ Prescription meds
- ☐ Injections
- ☐ Physical therapy
- ☐ Massage
- ☐ Describe the prior treatment you have had in the past:

The reason I am seeking care is for (select locations):





Please select the numbers from the drop-downs that best describe your pain overall:

INTENSITY: (No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst Possible Pain) 0

FREQUENCY: Pain Present 0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100% of the time 0%

My pain is relieved by:

- ☐ chiropractic care
- ☐ antacids
- ☐ bowel movement
- ☐ lying still
- ☐ taking a deep breath
- ☐ taking a short nap
- ☐ painkillers
- ☐ sleep
- ☐ taking Ibuprofen or Tylenol
- ☐ exercising
- ☐ resting
- ☐ sitting

My pain is:

- ☐ constant
- ☐ aching
- ☐ intermittent
- ☐ radiating
- ☐ sharp
- ☐ throbbing
- ☐ numbness
- ☐ tingling
- ☐ burning
- ☐ tight
- ☐ nausea
- ☐ vomiting
- ☐ visual disturbance
- ☐ altered hearing
- ☐ ringing in ears
- ☐ loss of balance
- ☐ Other:

My pain is aggravated by:

- ☐ Walking
- ☐ Stress
- ☐ Running
- ☐ Exercising
- ☐ Lifting Weight
- ☐ Jogging
- ☐ Climbing Stairs
- ☐ Bending Forward
- ☐ Bending Backwards
- ☐ Looking Up
- ☐ Looking Down
- ☐ Repetitious Movement
- ☐ Emotional Upset
- ☐ Flashing Lights
- ☐ Lifting Boxes
- ☐ Bowel movements

Current Prescription Medications

Name of Prescription	Dose (mg, ML)	Form (Tablet or Capsule)	Duration (times/day)

Allergies: ☐ None ☐ Drug Allergies: _____

Food Allergies: _____ Other Allergies: _____

Family Health History

What is the medical history of the following family members?
Mother: _____ Father: _____ Sister #1: _____
Sister #2: _____ Brother #1: _____ Brother #2: _____

Social Health History

Are you a student? ☐Yes ☐No Occupation: _____

Consume Caffeine? ☐Yes ☐No Consume Alcohol? ☐Yes ☐No Do you exercise? ☐Yes ☐No

Do you Smoke? ☐Yes ☐No Hobbies or Activities: _____

Past Medical History

Any past surgeries or hospitalizations? _____

_____

Female: Pregnant? ☐Yes ☐No

PATIENT REVIEW OF SYSTEMS

Please check the "**current"** box for all conditions that you are now experiencing and mark the "**past"** box for any condition or symptom(s) experienced at any time in your life. Please do not write in the spaces marked "**Doctor's Notes Only**".

	Current	Past	Doctor's Notes Only
GENERAL			
Fever	☐	☐	
Sweats	☐	☐	
Chills	☐	☐	
Fatigue	☐	☐	
Weight loss	☐	☐	
Weight gain	☐	☐	
Sleep disturbance	☐	☐	
Change in routine	☐	☐	
HEAD			
Headache	☐	☐	
Dizziness	☐	☐	
Head trauma	☐	☐	
Fainting	☐	☐	
Blacking out	☐	☐	
EYES			
Change in vision	☐	☐	
Glasses/Contacts	☐	☐	
Blurry vision	☐	☐	
Double vision	☐	☐	
Cataracts	☐	☐	
Sensitive to light	☐	☐	
Flashes in vision	☐	☐	
Spots in vision	☐	☐	
ENT			
Ringing in ears	☐	☐	
Frequent infection	☐	☐	
Hearing loss	☐	☐	
Drainage	☐	☐	
Ear pain	☐	☐	
Postnasal drip	☐	☐	
Nosebleeds	☐	☐	
Sinus problems	☐	☐	
Bleeding gums	☐	☐	
Cold sores	☐	☐	
Dentures	☐	☐	
Trouble Swallowing	☐	☐	
Sore throat	☐	☐	
Jaw pain	☐	☐	
Changes in taste	☐	☐	
Swelling	☐	☐	
Dental problems	☐	☐	
Hoarseness	☐	☐	
NECK			
Masses	☐	☐	
Swelling	☐	☐	
Stiffness	☐	☐	

	Current	Past	Doctor's Notes Only
LUNGS			
Difficulty breathing	☐	☐	
Asthma	☐	☐	
Pneumonia	☐	☐	
Wheezing	☐	☐	
Persistent cough	☐	☐	
Coughing up phlegm	☐	☐	
Coughing up blood	☐	☐	
Tuberculosis	☐	☐	
CARDIOVASCULAR			
Chest pain	☐	☐	
Palpitations	☐	☐	
Ankle swelling	☐	☐	
Cold feet or hands	☐	☐	
Discolored foot/hand	☐	☐	
Hot feet or hands	☐	☐	
Leg cramps	☐	☐	
Calf pain	☐	☐	
Varicose veins	☐	☐	
Low blood pressure	☐	☐	
High blood pressure	☐	☐	
G-I SYSTEM			
Gas/Belching	☐	☐	
Heartburn/Indigestion	☐	☐	
Ulcers	☐	☐	
Vomiting/Nausea	☐	☐	
Abdominal pain	☐	☐	
Diarrhea	☐	☐	
Constipation	☐	☐	
Blood in stool	☐	☐	
Hemorrhoids	☐	☐	
Gall bladder disease	☐	☐	
Liver disease	☐	☐	
G-U SYSTEM			
Bed wettng	☐	☐	
Difficulty/Pain urinating	☐	☐	
Blood in urine	☐	☐	
Incontinence	☐	☐	
Foul odor of urine	☐	☐	
Increased urination	☐	☐	
Decreased urination	☐	☐	
Urinary infection	☐	☐	
Genital infection	☐	☐	
Kidney stones	☐	☐	

	Current	Past	Doctor's Notes Only
PSYCHOLOGIC			
Excessive Stress	☐	☐	
Depression	☐	☐	
Anxiety	☐	☐	
Mood swings	☐	☐	
SKIN			
Rash	☐	☐	
Bruising	☐	☐	
Hair loss	☐	☐	
Warts	☐	☐	
Brittle nails	☐	☐	
Changes in moles	☐	☐	
Itching	☐	☐	
Peeling	☐	☐	
NEUROLOGIC			
Seizures/Epilepsy	☐	☐	
Strokes	☐	☐	
Tingling sensation	☐	☐	
Numbness	☐	☐	
Weakness	☐	☐	
Difficulty walking	☐	☐	
Poor coordination	☐	☐	
MUSCLE/BONE			
Joint pain	☐	☐	
Stiffness	☐	☐	
Muscle ache	☐	☐	
Arthritis	☐	☐	
Deformity	☐	☐	
Bone pain	☐	☐	
Fractures	☐	☐	
Dislocations	☐	☐	

	Current	Past	Doctor's Notes Only
MEDICATION			
Prescription medications	☐	☐	
Non-prescribed medication	☐	☐	
Drug allergies	☐	☐	
Recreational drugs	☐	☐	
OB GYN – For Females			
Age period began	_____		
Last breast exam	_____		
Last PAP date	_____		
Pregnancy(s)- past	_____		
Pregnancy	☐	☐	
Mastectomy	☐	☐	
Lumps in breast	☐	☐	
Nipple discharge	☐	☐	
Hysterectomy	☐	☐	
PMS	☐	☐	
Irregular periods	☐	☐	
Hot flashes	☐	☐	
Menstrual cramps	☐	☐	
CONDITIONS			
Hypertension	☐	☐	
Diabetes	☐	☐	
Thyroid condition	☐	☐	
Heart condition	☐	☐	
Rheumatic arthritis	☐	☐	
Rheumatic Fever	☐	☐	
Glaucoma	☐	☐	
Alcoholism	☐	☐	
Cancer / Tumor	☐	☐	
Polio	☐	☐	
Parkinson's	☐	☐	
Multiple Sclerosis	☐	☐	
Gout	☐	☐	
Anemia	☐	☐	
Osteoporosis	☐	☐	

QUALITY CARE
CHIROPRACTIC AND WELLNESS

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: _____ DOB: _____

Receipt of Notice of Privacy Practices

I acknowledge I have received, or I have been provided the opportunity to receive a copy of Quality Care Chiropractic and Wellness's Notice of Privacy Practices that explains when, where and why my protected health information may be used or shared by Quality Care Chiropractic and Wellness. I may obtain a current copy by contacting Quality Care Chiropractic and Wellness's Privacy/Security Official, or by visiting Quality Care Chiropractic and Wellness's web site at www.QualityCareChiropractic.org

HIPAA Disclosure Authorization(s)

I authorize Quality Care Chiropractic and Wellness to:

Contact me at the following number(s): _____

Leave a voice message with me at the following number(s): _____

Provide the following person(s) with my protected health information:

Print Name: _____ Relationship to Patient/Phone number: _____

Print Name: _____ Relationship to Patient/Phone number: _____

I do not authorize Quality Care Chiropractic and Wellness to disclose my protected health information to anyone other than myself, except as permitted by HIPAA and as described in Quality Care Chiropractic and Wellness's Notice of Privacy Practices.

HIPAA Unencrypted Communication Authorizations

Electronic mail (email) and text messaging are common forms of communication and can be utilized to communicate with your physician and your care team. It is important for you to understand that unencrypted email and text messaging are not secure communications. This means there is a potential risk that messages containing your protected health information may be intercepted by a third party. Encryption is the process of making information unreadable unless you have the password or key to decrypt the information. Quality Care Chiropractic and Wellness does not encrypt text messages, and we cannot guarantee that all email messages will be encrypted.

By initialing below and signing this authorization, I understand and accept the conditions outlined above. I authorize Quality Care Chiropractic and Wellness to send unencrypted communications to the email address and/or phone number listed below.

I authorize Quality Care Chiropractic and Wellness to:

Initial ____ Send email to the following address: _____

Initial ____ Send text messages to the following phone number: _____

I understand the HIPAA Disclosure Authorization(s) above may be revoked in writing at any time; however, the revocation will not affect disclosures of information previously authorized. I understand this authorization is valid while I continue to receive services from any Quality Care Chiropractic and Wellness provider.

My signature below acknowledges that I have been provided with a copy of the *Notice of Privacy Practices:*

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Print Name Relationship to Patient

For Practice Use Only: Complete this section if you are unable to obtain a signature.

If the Patient or personal representative is unable or unwilling to sign this *Acknowledgement*, or the *Acknowledgement* is not signed for any other reason, state the reason:

_____

Completed by: _____ _____
Signature of Practice Representative Date

I have received my examination and the doctor explained to me what he/she found. Based on this, I give my permission to have diagnostic tests, procedures, and a chiropractic treatment plan for my condition(s).

QUALITY CARE
CHIROPRACTIC AND WELLNESS

Informed Consent for Diagnostic and Treatment Procedures

I have received my examination and the doctor explained to me what he/she found. Based on this, I give my permission to have diagnostic tests, procedures, and a treatment plan for my condition(s). I understand that the treatment I receive at this clinic is from a licensed Doctor of Chiropractic. Chiropractic scope of practice includes a wide range of services, but if the clinician determines the services I need cannot be provided by this office, then he/she will direct me to the appropriate health care provider.

Within the service provided by this office, treatment almost always includes either physical therapy procedures including exercise, manual therapy, and functional activities or the chiropractic adjustment, a specific type of joint manipulation. Spinal manipulation and physical therapy modality procedures are done to ease pain and/or help the body function better. Like most health care procedures, spinal manipulation and physical therapy procedures carry with it some risks. Unlike many such procedures, the serious risks associated with spinal manipulation and physical therapy procedures are extremely rare. **The following are the potential risks:**

- ☐ **Temporary soreness or increased symptoms or pain** It is not uncommon for patients to experience temporary soreness or increased symptoms or pain after the first few treatments.
- ☐ **Dizziness, nausea, flushing** These symptoms are relatively rare. It is important to notify the doctor if you experience these symptoms during or after your care.
- ☐ **Fractures** When patients have underlying conditions that weaken bones, like osteoporosis, they may be susceptible to fracture. It is important to notify your doctor if you have been diagnosed with a bone weakening disease or condition. If your doctor detects any such condition while you are under care, you will be informed, and your treatment plan will be modified to minimize risk of fracture.
- ☐ **Disc herniation or prolapse** Spinal disc conditions like bulges or herniations may worsen even with chiropractic care. It is important to notify your doctor if symptoms change or worsen.
- ☐ **Stroke** According to the most recent research, there is no evidence of excess risk of stroke associated with chiropractic care. Regarding neck pain and headache symptoms, there is an association between stroke and visits to all provider-types, including primary care medical visits, which may occur before or during the provider visit.
- ☐ **Other risks** associated with chiropractic treatment include rare burns from physiotherapy devices that produce heat.
- ☐ **Bruising** Instrument assisted soft tissue manipulation may result in temporary soreness or bruising.
- ☐ **Alternatives** to manipulation discussed through a shared decision-making process include Medicines, Physical Therapy, Massage, Mobilization, Acupuncture, and/or Cognitive-behavioral therapy. You can do these whether or not you are doing spinal manipulation.
- ☐ **Refusing diagnostic and/or treatment procedures** may carry a risk to future capabilities in regard to performing activities of daily living or progression towards chronic pain.

☐ I am not pregnant to my knowledge (date of last menstrual cycle: _____). I have been advised that it may not be advisable to be exposed to x-rays if I believe that there is a possibility that I am pregnant.

I understand that the practice of chiropractic, like the practice of all healing arts, is not an exact science, and I acknowledge that no guarantee can be given as to the results or outcome of my care. The material risks have been disclosed to me, including a description of those material risks; and after consideration, I agree to the procedures understanding any material risks which are inherent to that procedure.

● PATIENT PLEASE REVIEW ● PRINT & SIGN NAME ●

I have read or had read to me this informed consent document. I have discussed or been given the opportunity to discuss any questions or concerns with my chiropractor and have had these answered to my satisfaction prior to my signing this informed consent document. I have made my decision voluntarily and freely.

PATIENT'S NAME (PRINT)_____ **DATE OF BIRTH:** _____

PATIENT GUARDIAN/REPRESENTATIVE (PRINT) _____

_____ _____ _____ _____

(PATIENT GUARDIAN/REPRESENTATIVE SIGNATURE) **(DATE)** **(TRANSLATOR | INTERPRETER SIGNATURE)** **(DATE)**

CLINICIAN ONLY

Based on my personal observation, the patient's history and physical exam, I conclude that throughout the informed consent process the patient was:

□ OF LEGAL AGE □ APPEARS UNIMPAIRED □ CONSENT GIVEN THROUGH GUARDIAN/PATIENT REPRESENTATIVE
□ ORIENTED X3 □ FLUENT IN ENGLISH □ ASSISTED BY A TRANSLATOR OR INTERPRETER

_____, D.C. _____

(CLINICIAN SIGNATURE) **(DATE)**

STUDENT INTERN/EXTERN INITIALS AS WITNESS TO PATIENT DISCUSSION WITH CLINICIAN: _____