SPINE BY DESIGN CHIROPRACTIC

*Discover the Gonstead Difference*

Spine by Design, Inc.

62 Maverick Street, Rockland, ME 04841

Ph.207.593.8796 Fax.888.965.5221

spinebydesign@outlook.com

Name_____DOB_____

Address _____ Gender_____

_____ Home phone _____

Email _____Mobile

_____

Marital status _____Spouse's name _____

Guardian (if applicable) _____

Emergency contact _____Phone _____

Family doctor _____

Occupation _____Employer _____

Children's names and ages _____

_____

**Current Health Conditions**

Reason for the visit:_____

When did it start? _____

How did the condition(s) first begin? _____

_____

Have you received care for this problem? If yes, explain. _____

_____

What makes the problem better? _____

What makes the problem worse? _____

Is the condition: □ getting worse □ improving □ no change

Is the condition: □ intermittent □ constant □ unsure

Describe the pain: □ aching □ deep □ sharp □ dull

□ burning □ throbbing □ numb □ tingling □ other

Rate your pain level: □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

Have you had any significant falls, surgeries, accidents (including auto), or injuries as an adult? If yes, please explain. _____

_____

_____

_____

Notable childhood injuries: _____

Youth or college sports: _____

Have you ever been hospitalized? If yes, why? _____

_____

_____

How do you normally sleep? □ Back □ Side □ Stomach

Do you wake up: □ Refreshed □ Tired and stiff

Do you commute to work? If yes, how many minutes of commute time? _____

How many hours per day to you typically spend sitting? _____

What types of exercise do you perform? How frequent? _____

_____

Have you visited a Chiropractor before? If yes, for what reason and did it help? _____

_____

What would you like to gain from Chiropractic care? □ Resolve existing conditions

□ Overall wellness □ Both

**Health History**

Have YOU or any IMMEDIATE family members have/had any of the following:

□ Rheumatoid arthritis □ Diabetes □ Lupus □ High blood pressure

□ Stroke □ Heart disease □ Cancer

Please specify who has/had the condition: _____

_____

Please check any conditions below that YOU have/had:

| | | |
|---|---|---|
| □ Headaches | □ Broken bones | □ Liver disease |
| □ Neck pain | □ Pacemaker | □ Thyroid problems |
| □ Upper back pain | □ Dizziness | □ Asthma |
| □ Midback pain | □ Heart attack | □ Sinus problems |
| □ Low back pain | □ Chest pain | □ Excessive thirst |
| □ Shoulder pain | □ Angina | □ Frequent urination |
| □ Arm pain | □ Kidney stones | □ Tobacco use |
| □ Wrist pain | □ Kidney disorders | □ Drug/alcohol dependence |
| □ Hand pain | □ Loss of bladder control | □ Allergies |
| □ Upper leg pain | □ Painful urination | □ Depression/anxiety |
| □ Hip pain | □ Bladder infection | □ Epilepsy |
| □ Knee pain | □ Prostate problems (men) | □ Dermatitis/eczema/rash |
| □ Ankle/foot pain | □ Abnormal weight change | □ Hormone replacement |
| □ Jaw pain | □ Loss of appetite | □ Birth control |
| □ Joint swelling | □ Abdominal pain | □ Pregnancy |
| □ Arthritis | □ Ulcer | □ Muscle incoordination |
| □ General fatigue | □ Hepatitis | □ Loss of balance |
| □ Vision problems | □ Tumor | □ Loss of concentration |
| □ Ringing in the ears | □ Gall bladder problems | □ Anemia |
| □ Memory problems | □ Sensitivity to light | □ Osteoporosis |
| □ Cold hands/feet | □ Concussion | □ Other |

Women only: Are you pregnant? _____ Due date _____

Are you currently nursing? _____

Please list any allergies: _____

Please list any drugs/medications/herbs/vitamins/supplements/other that you are taking and why:

_____

_____

_____

Rate your consumption for the following: (0=never, 5=high)

| | | | |
|---|---|---|---|
| Alcohol | □ 1 □ 2 □ 3 □ 4 □ 5 | Processed foods | □ 1 □ 2 □ 3 □ 4 □ 5 |
| Water | □ 1 □ 2 □ 3 □ 4 □ 5 | Artificial sweeteners | □ 1 □ 2 □ 3 □ 4 □ 5 |
| Sugar | □ 1 □ 2 □ 3 □ 4 □ 5 | Sugary drinks | □ 1 □ 2 □ 3 □ 4 □ 5 |
| Dairy | □ 1 □ 2 □ 3 □ 4 □ 5 | Cigarettes/Tobacco | □ 1 □ 2 □ 3 □ 4 □ 5 |
| Gluten | □ 1 □ 2 □ 3 □ 4 □ 5 | Recreational drugs | □ 1 □ 2 □ 3 □ 4 □ 5 |
| Caffeine | □ 1 □ 2 □ 3 □ 4 □ 5 | Fast food | □ 1 □ 2 □ 3 □ 4 □ 5 |

Please rate your stress level for each: (0=none, 5=high)

| | | | |
|---|---|---|---|
| Home | □ 1 □ 2 □ 3 □ 4 □ 5 | Money | □ 1 □ 2 □ 3 □ 4 □ 5 |
| Work | □ 1 □ 2 □ 3 □ 4 □ 5 | Health | □ 1 □ 2 □ 3 □ 4 □ 5 |
| Life | □ 1 □ 2 □ 3 □ 4 □ 5 | Family | □ 1 □ 2 □ 3 □ 4 □ 5 |

## Accuracy of Information

□ I certify that the above medical information is correct to my knowledge

## Patient Privacy and HIPAA Notice:

I understand and agree to allow this chiropractic office to use my Patient Health Information for the purpose of treatment, payment, healthcare operation, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like a more detailed account of your policy and procedures concerning the privacy of your Patient Health Information, we encourage you to read the HIPAA Notice that is available for you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office in writing. The full text of our HIPAA available in the office and on our website.

□ I agree to this use of my Patient Health Information

## Informed Consent for Chiropractic Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions there are some risks to care, including but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, jack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains.

With respect to strokes, there is a rare but serious condition known as an '{arterial dissection" that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus Cot) with the potential to lead to a stroke. The best available scientific evidence supports the

understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately, a percentage of these patients will experience a stroke. The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major Gi events of the entire (upper and lower) Gi tract was 1219 events/per one million persons/year and risk of death has been estimated as 104 per one million users. It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit. I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

□ I consent to evaluation and care in this office

## Financial Policy

Payment is due at the time services are rendered. This practice does not accept private insurances, but will provide a superbill with appropriate diagnosis and treatment codes for you to submit to your plan for any reimbursement you may be eligible for. Services in this office will qualify towards your deductible as well.

□ I agree to the financial policy

_____ _____

Signature Date