

Patient Information

Date:	SSN:	Birthday:
First Name:	Middle Name:	Last Name:
Sex: <input type="radio"/> M <input type="radio"/> F	Height:	Weight:
Marital Status: <input type="radio"/> Yes <input type="radio"/> No	Spouse Name:	# of Children:
Home #:	Cell #:	Work #:
Address:		
City:	State:	Zip:
Emergency Contact:	Emergency Relation:	Emergency Phone:
Email:		

Referral Information

Referring Physician:	Referred Patient:	Referred by:
Advertisement: <input type="radio"/> Yes <input type="radio"/> No	Advertisement:	
Referred Directory: <input type="radio"/> Yes <input type="radio"/> No	Referred Directory:	

Employer Information

Employed: <input type="radio"/> Full Time <input type="radio"/> Part Time <input type="radio"/> Homemaker <input type="radio"/> Unemployed	Employer Name:	
Employer Address:		
Employer City:	Employer State:	Employer Zip:
Occupation:	Work Supervisor:	Supervisor #:
Work Duties:		

Insurance Information

Payment: <input type="radio"/> Personal <input type="radio"/> 3rd Party <input type="radio"/> Self	Resp. for Payment:	Responsible Phone :
Payment Name:	Primary Phone #:	Primary ID/Policy:
Payment Address:		
Payment City:	Payment State:	Payment Zip:
Primary Group #:	Primary Name:	Primary DOB:
Secondary Name:	Secondary Phone #:	Secondary ID/Policy:
Secondary Address:		
Secondary City:	Secondary State:	Secondary Zip:
Secondary Group #:	Secondary Name:	Secondary DOB:
Claim #:	Claim Contact:	Claim Phone #:
Attorney Name:	Attorney Phone #:	

Complaint Information

Injury Occurred:	<input type="radio"/> Automobile	<input type="radio"/> Work	<input type="radio"/> Third-Party	<input type="radio"/> Other	Injury Date:	_____
Injury Origin:	_____					
Desc Discomfort:	_____					
Frequency:	<input type="radio"/> Always	<input type="radio"/> Hourly	<input type="radio"/> Daily	<input type="radio"/> Occasionally		
Interfere w/ Activities:	<input type="radio"/> Yes	<input type="radio"/> No	Affected Sleep:	<input type="radio"/> Yes	<input type="radio"/> No	
Missed Work:	<input type="radio"/> Yes	<input type="radio"/> No	Unable to Work from:	_____	Unable to Work til:	_____
Affected Appetite:	<input type="radio"/> Yes	<input type="radio"/> No	Explain:	_____		
Reduced Work:	<input type="radio"/> Yes	<input type="radio"/> No	Explain:	_____		
Does it Worsen:	<input type="radio"/> Yes	<input type="radio"/> No	Explain:	_____		
Weather Affects it:	<input type="radio"/> Yes	<input type="radio"/> No	Explain:	_____		
Aggravates Condition:	_____					
Improves Condition:	_____					
Received Treatment:	<input type="radio"/> Yes	<input type="radio"/> No	Explain:	_____		
X-rays Taken:	<input type="radio"/> Yes	<input type="radio"/> No	Explain:	_____		
Same Condition Before:	<input type="radio"/> Yes	<input type="radio"/> No	Date:	_____	Practitioner:	_____

History

Last Physical Exam:	_____	Primary Phys:	_____	Phys Phone #:	_____		
Phys City:	_____	Phys State:	_____	Phys Zip:	_____		
Health Conditions:	_____						
Surgeries/Hosp:	_____						
Previous Chiro Care:	<input type="radio"/> Yes	<input type="radio"/> No	Date:	_____	Explain:	_____	
Chance Pregnant:	<input type="radio"/> Yes	<input type="radio"/> No	Planning:	<input type="radio"/> Yes	<input type="radio"/> No		
Medications:	_____						
Supplements:	_____						
Broken Bones:	<input type="radio"/> Yes	<input type="radio"/> No	Treatment:	<input type="radio"/> Yes	<input type="radio"/> No	Explain:	_____
Sprains/Strains:	<input type="radio"/> Yes	<input type="radio"/> No	Treatment:	<input type="radio"/> Yes	<input type="radio"/> No	Explain:	_____
Hospitalized:	<input type="radio"/> Yes	<input type="radio"/> No	Explain:	_____			
Surgery:	<input type="radio"/> Yes	<input type="radio"/> No	Explain:	_____			
Auto Accident:	<input type="radio"/> Yes	<input type="radio"/> No	Treatment:	<input type="radio"/> Yes	<input type="radio"/> No	Explain:	_____
Struck Unconscious:	<input type="radio"/> Yes	<input type="radio"/> No	Treatment:	<input type="radio"/> Yes	<input type="radio"/> No	Explain:	_____
Eating Disorder:	<input type="radio"/> Yes	<input type="radio"/> No	Explain:	_____			
Stroke:	<input type="radio"/> Yes	<input type="radio"/> No	Explain:	_____			
Family Health Hist:	_____						

Patient Social

Alcohol:	<input type="radio"/> Daily	<input type="radio"/> Weekly	<input type="radio"/> Occasion	<input type="radio"/> Never	Caffeine:	<input type="radio"/> Daily	<input type="radio"/> Weekly	<input type="radio"/> Occasion	<input type="radio"/> Never
Diet Food Products:	<input type="radio"/> Daily	<input type="radio"/> Weekly	<input type="radio"/> Occasion	<input type="radio"/> Never	Drugs:	<input type="radio"/> Daily	<input type="radio"/> Weekly	<input type="radio"/> Occasion	<input type="radio"/> Never
OTC Stimulants:	<input type="radio"/> Daily	<input type="radio"/> Weekly	<input type="radio"/> Occasion	<input type="radio"/> Never	Exercise:	<input type="radio"/> Daily	<input type="radio"/> Weekly	<input type="radio"/> Occasion	<input type="radio"/> Never
Homemade Food:	<input type="radio"/> Daily	<input checked="" type="radio"/> Weekly	<input type="radio"/> Occasion	<input type="radio"/> Never	Processed Food:	<input type="radio"/> Daily	<input type="radio"/> Weekly	<input type="radio"/> Occasion	<input type="radio"/> Never
Soft Drinks:	<input type="radio"/> Daily	<input type="radio"/> Weekly	<input type="radio"/> Occasion	<input type="radio"/> Never	Tobacco:	<input type="radio"/> Daily	<input type="radio"/> Weekly	<input type="radio"/> Occasion	<input type="radio"/> Never
Water:	<input type="radio"/> Daily	<input type="radio"/> Weekly	<input type="radio"/> Occasion	<input type="radio"/> Never					

Health Checklist

<input type="checkbox"/> Allergies	<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Anemia
<input type="checkbox"/> Arteriosclerosis	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Asthma
<input type="checkbox"/> Back Pain	<input type="checkbox"/> Breast Lump	<input type="checkbox"/> Bronchitis
<input type="checkbox"/> Bruise Easily	<input type="checkbox"/> Cancer	<input type="checkbox"/> Chest Pain
<input type="checkbox"/> Cold Extremities	<input type="checkbox"/> Constipation	<input type="checkbox"/> Cramps
<input type="checkbox"/> Depression	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Digestion Problems
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Excessive Menstruation	<input type="checkbox"/> Eye Pain or Difficulties
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Frequent Urination	<input type="checkbox"/> Headache
<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Hot Flashes
<input type="checkbox"/> Irregular Heart Beat	<input type="checkbox"/> Irregular Menstrual Cycle	<input type="checkbox"/> Kidney Infection
<input type="checkbox"/> Kidney Stones	<input type="checkbox"/> Loss of Memory	<input type="checkbox"/> Loss of Balance
<input type="checkbox"/> Loss of Smell	<input type="checkbox"/> Loss of Taste	<input type="checkbox"/> Nosebleeds
<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Polio	<input type="checkbox"/> Poor Posture
<input type="checkbox"/> Prostate Trouble	<input type="checkbox"/> Sciatica	<input type="checkbox"/> Shortness of Breath
<input type="checkbox"/> Spinal Curvatures	<input type="checkbox"/> Sinus Infection	<input type="checkbox"/> Insomnia
<input type="checkbox"/> Swollen Joints	<input type="checkbox"/> Stroke	<input type="checkbox"/> Swelling of Ankles
<input type="checkbox"/> Ulcers	<input type="checkbox"/> Thyroid Condition	<input type="checkbox"/> Tuberculosis
	<input type="checkbox"/> Varicose Veins	<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Other: _____		

Patient Signature: _____ Date: _____

Informed Consent to 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 chiropractic adjustment. There may be additional supportive procedures or therapies as well. When providing an adjustment, we use our hands and/or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reduce 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, lack 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, fracture (broken bones), disc injuries, strokes, dislocations, strains, and sprains.

With respect to strokes, there is a rare but serious condition known as a cervical arterial dissection that involves an abnormal change in the wall of an artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. This occurs 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. As chiropractic care can involve manually and/or mechanically adjusting the cervical spine, it has been reported that chiropractic care may be a risk for developing this type of stroke. The association with stroke is exceedingly rare.

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 & staff in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: _____ Signature: _____ Date: _____

Witness Name: _____ Signature: _____ Date: _____

You may request a restriction by presenting your request, in writing to the staff member identified as "Privacy Officer" at the top of this form. The Privacy Officer will provide you with "Restriction of Consent" form. Complete the form, sign it, and ask that the staff provide you with a photocopy of your request initialed by them. This copy will serve as your receipt.

- **You have the right to request to receive confidential communications from us by alternative means or at an alternative location.** We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing.
- **You may have the right to have your doctor amend your protected health information.** This means you may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Officer if you have questions about amending your medical record.
- **You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.** This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy practices. It excludes disclosures we may have made to you, to family members or friends involved in your care, pursuant to a duly executed authorization or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. The right to receive this information is subject to certain exceptions, restrictions and limits.
- **You have the right to be notified by our office of any breach of privacy of your Protected Health Information.**

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

C. Complaints

You may complain to us, or the Secretary of Health and Human Services, if you believe your privacy rights have been violated by us. *To file a complaint you may go to:*

<http://www.hhs.gov/ocr/privacy/hipaa/complaints/hipcomplaintform.pdf>

Or our office can provide you with a written form in which to file your complaint. You may also file a complaint with us by notifying our Privacy Officer of your complaint. We will not retaliate against you for filing a complaint.

Our Privacy Officer is Grace Vik. You may contact our Privacy Officer, or any staff member, including Drs. Elder, Solom or Schnarr at the following phone number 314-567-7300 or our website, at www.metrochiro.com for further information about the complaint process.

Patient signature

date

HIPAA compliance officer

date

This notice was published and becomes effective on April 1st, 2020

PATIENT AND DOCTOR AGREEMENT

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's office will prepare all necessary reports and forms to assist me in making collection from the insurance company, and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment.

I understand I am financially responsible for all charges approved by said insurance. I, with this, authorize a said assignee to release all information to secure payment. I agree to pay a service charge on all delinquent amounts more than 30 days past due. This charge will be computed at a rate of 1 ½% per month, 18% per annum. I will also be responsible for all costs incurred in the collection of my account.

I hereby authorize the Doctor to treat my condition as the Doctor deems appropriate through adjusting my spinal column. I understand and agree that the amount paid the Doctor for x-rays is for examination only and the x-ray negatives will remain the property of this office. I also agree that I am responsible for all bills incurred at this office that are approved by my insurance company. The Doctor will not be held responsible for any preexisting medically diagnosed conditions, nor for any medical diagnosis.

Patient Signature X _____ Date _____

Guardian or Spouses Signature
Authorizing Care X _____ Date _____