Patient Confidentiality Personal Data

Date_____

Patient_____Date of Birth_____

Home Address_____City_____State_____Zip_____

Social Security No_____Home_____Cell_____

Email_____Cell Carrier_____

Employer_____Address_____

- Name of Spouse_____No of Children_____

How did you learn about our office? _____

Nearest Relative not living with you for emergency contact_____Phone_____

Who is responsible for payment? Self_____Spouse_____Other_____

Purpose of this appointment and list your
complaints_____
Date of illness_____
How did accident occur? Auto Accident_____Work Injury_____Other_____
Please describe the circumstances and what makes it better or worse_____
_____
Other doctors seen for the condition_____
Have you been treated by a doctor for any other condition in the past year? Yes____NO_____
If yes please describe_____

INSURNCE INFORMATION

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that Anderson Hills Chiropractic will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

Physicians Signature_____ Patients Signature_____

Consent of Professional Services and Release of Information:
I hereby authorize the doctor and whomever he may designate as his assistants to administer treatment, physical examination, x-ray studies, laboratory procedures, chiropractic care or any clinic services that he/she deems necessary in any case: and I further authorize him/her to disclose all or any part of my (patient's) record to any person or corporation which is or may be liable under a contract to the clinic or to the patient or to a family member or employer of the patient for all or part of the clinic's charge, including, and not limited to , hospital or medical services companies, insurance companies, workers compensation carriers, welfare funds, or the patients employer. Patients Signature_____

Parent's or Guardian's Signature_____

HEALTH QUESTIONNAIRE

Please Check Mark Each of the Conditions Below that You are Currently Experiencing

Patient: _____ **Date:** _____

No.: _____

MUSCULO SKELETAL SYSTEM

- ☐ Low back pain
- ☐ Mid back pain
- ☐ Pain between shoulders
- ☐ Neck pain
- ☐ Arm problems
- ☐ Leg problems
- ☐ Swollen joints
- ☐ Painful joints
- ☐ Stiff joints
- ☐ Sore muscles
- ☐ Weak muscles
- ☐ Walking problems
- ☐ Spasms
- ☐ Broken bones
- ☐ Shoulder pain

GENITO-URINARY SYSTEM

- ☐ Bladder trouble
- ☐ Excessive urination
- ☐ Scanty urination
- ☐ Painful urination
- ☐ Discolored urine

FEMALE

- ☐ Vaginal discharge
- ☐ Vaginal bleeding
- ☐ Vaginal pain
- ☐ Breast pain
- ☐ Lumps on the breast

ARE YOU PREGNANT?

☐ YES ☐ NO

GASTRO-INTESTIONAL SYSTEM

- ☐ Poor appetite
- ☐ Excessive hunger
- ☐ Difficult chewing
- ☐ Difficult swallowing
- ☐ Excessive thirst
- ☐ Nausea
- ☐ Vomiting Blood
- ☐ Abdominal pain
- ☐ Diarrhea
- ☐ Constipation
- ☐ Black stool
- ☐ Bloody stool
- ☐ Hemorrhoids
- ☐ Liver trouble
- ☐ Gall bladder problems
- ☐ Weight trouble

NERVOUS SYSTEM

- ☐ Numbness
- ☐ Loss of feeling
- ☐ Paralysis
- ☐ Dizziness
- ☐ Fainting
- ☐ Headaches
- ☐ Muscles jerking
- ☐ Convulsions
- ☐ Forgetfulness
- ☐ Confusion
- ☐ Depression
- ☐ Insomnia

HABITS

- ☐ Cigarettes
- ☐ Alcohol Abuse
- ☐ Coffee or Tea
- ☐ Drug Abuse
- ☐ _____

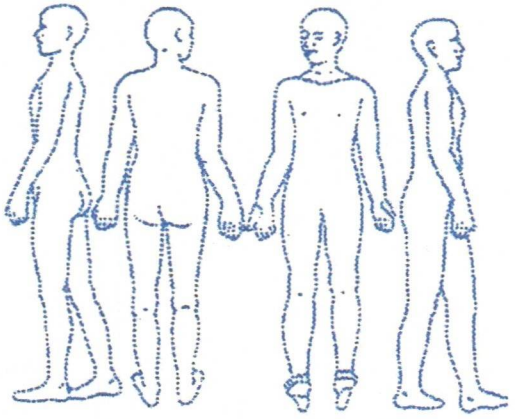
CARDIO-VASCULAR RESPIRATORY

- ☐ Chest pain
- ☐ Pain over heart
- ☐ Difficult breathing
- ☐ Persistent cough
- ☐ Coughing phlegm
- ☐ Coughing blood
- ☐ Rapid heartbeat
- ☐ Blood pressure problems
- ☐ Heart problems
- ☐ Lung problems
- ☐ Varicose veins

EYE, EAR, NOSE AND THROAT

- ☐ Eye strain
- ☐ Eye inflammation
- ☐ Vision problems
- ☐ Ear pain
- ☐ Ear noises
- ☐ Ear discharge
- ☐ Hearing loss
- ☐ Nose pain
- ☐ Nose bleeding
- ☐ Nose discharge
- ☐ Difficult breathing through nose
- ☐ Sore gums
- ☐ Dental problems
- ☐ Sore mouth
- ☐ Sore throat
- ☐ Hoarseness
- ☐ Difficult speech
- ☐ Sinus
- ☐ Allergy
- ☐ Jaw Pain

SYMPTOM LOCALIZATION



P ___ Pain T ___ Tender

N ___ Numb H ___ Hypoesthesia

S ___ Spasm

Pain Index

Least 1 2 3 4 5 6 7 8 9 10 Worst

Patient's Signature _____

●●●●●●●●●●●●●●●●●●●●●●●●DO NOT WRITE BELOW THIS LINE●●●●●●●●●●●●●●●●●●●●●●●●

_____

_____

_____

_____

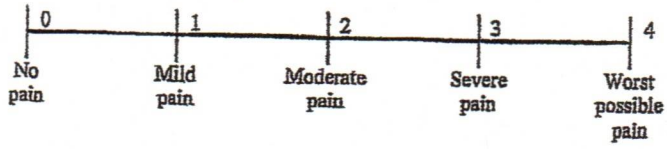
Patient Accepted? ☐ Yes ☐ No **Doctor's Signature** _____

Functional Rating Index

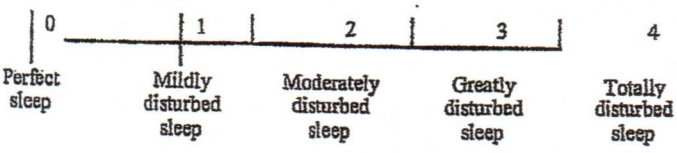
For use with Neck and/or Back Problems only.

In order to properly assess your condition, we must understand how much your **neck and/or back problems** has affected your ability to manage everyday activities. For each item below, **please circle the number which most closely describes your condition right now.**

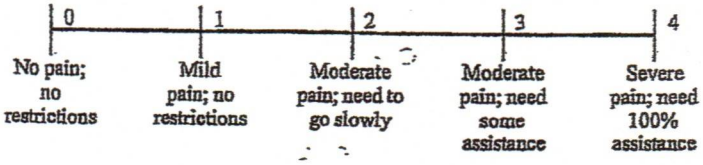
1. Pain Intensity



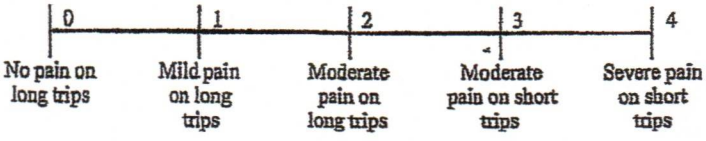
2. Sleeping



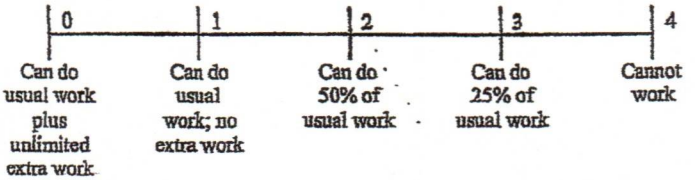
3. Personal Care (washing, dressing, etc.)



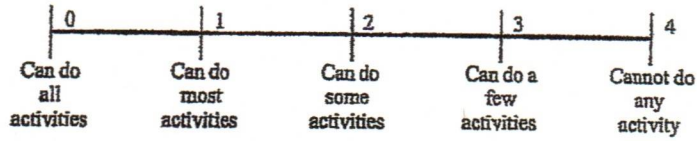
4. Travelling (driving, etc.)



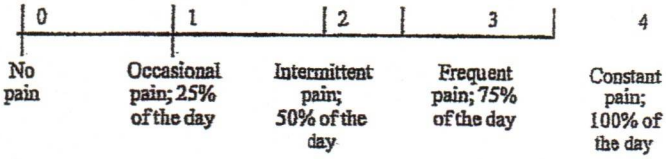
5. Work



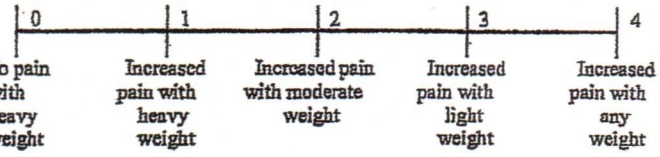
6. Recreation



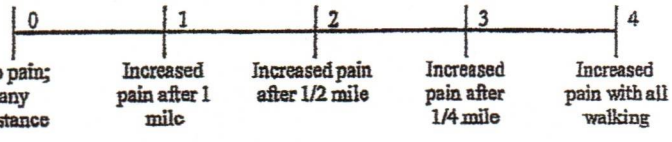
7. Frequency of Pain



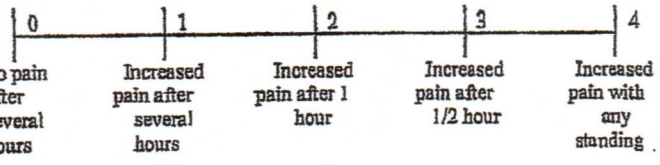
8. Lifting



9. Walking



10. Standing



[redacted] [redacted]

Patient's Signature **Date**

For Office Use Only:

Practitioner ID#: _____

Total Score _____ / 40

Clinical Diagnosis Codes:

Patient ID#: _____

ANDERSON HILLS CHIROPRACTIC

Records Release

Patients Name: _____ D.O.B._____

Address:_____

City:_____State:_____Zip:_____

I hereby authorize and request_____to release

Information pertaining to my health records and treatment including consultation on conditions, xrays, and MRI's concerning the undersigned:

To: Anderson Hills Chiropractic
7758 Beechmont Ave
Cincinnati, Ohio 45255

phone:513-232-5999
fax: 513-232-5899

Patients Signature:_____ Date:_____

Witness Signature_____ Date:_____

INFORMED CONSENT

Dear Patient:

Every type of health care is associated with some risk of a potential problem. This includes chiropractic health care. We want you to be informed about potential problems associated with chiropractic health care before consenting to treatment. This is called informed consent.

Chiropractic adjustments are the moving of bones with the doctor's hands or with the use of a machine. Frequently adjustments create a "pop" or "click" sound/sensation in the area being treated. In this office we use trained staff personnel to assist the doctor with portions of your consultation, examination, x-ray taking, physical therapy application, exercise instruction, spinal decompression therapy etc.

Strokes: Stroke is the most serious problem that has been associated with chiropractic adjustments. Stroke means that a portion of the brain does not receive enough oxygen from the blood stream. The results can be temporary or permanent dysfunction of the brain, with a very rare complication of death. In extremely rare instances chiropractic adjustments have been associated with strokes that arise from the vertebral artery only; this is because the vertebral artery is actually found inside the neck vertebrae. Certain types of neck adjustments may potentially be related to vertebral artery strokes, but no one is certain. The most recent studies (Journal of the CCA, vol. 37, June, 1993) estimate that the incident of this type of stroke is 1 per every 3,000,000 upper neck adjustments. This means that an average chiropractor would have to be in practice for hundreds of years before they would statistically be associated with a single patient stroke.

Disc herniations: Disc herniations that create pressure on the spinal nerve or on the spinal cord are frequently successfully treated by chiropractors and chiropractic adjustments, traction, spinal decompression therapy etc. This includes both neck and back. Yet, occasionally chiropractic treatment (adjustments, traction, spinal decompression therapy etc.) will aggravate the problem and rarely surgery may become necessary for correction. Rarely chiropractic adjustments may also cause worsening of a pre-existing disc problem if the disc is in a weakened condition. These problems occur so rarely that there are no available statistics to quantify their problem.

Soft tissue injury: Soft tissues primarily refer to muscles and ligaments. Muscles move bones and ligaments limit joint movement. Rarely chiropractic adjustments, traction, massage therapy, spinal decompression therapy etc., may tear some muscle or ligament fibers. The result is temporary increase in pain and necessary treatments of resolution, but there are no long term effects for the patient. These problems occur so rarely that there are no available statistics to quantify their probability.

Rib fractures: The ribs are found only in the thoracic spine or middle back. They extend from your back to your front chest area. Rarely a chiropractic adjustment will crack a rib bone, and this is referred to as a fracture. This occurs only on patients that have weakened bones from such things as osteoporosis. Osteoporosis can be noted on your x-rays. We adjust all patients very carefully, and especially those who have osteoporosis on their x-rays. These problems occur so rarely that there are no available statistics to quantify their probability.

Physical therapy burns: Some of the machines we use generate heat. We also use both heat and ice, and recommend them for home care on occasion. Everyone's skin has a different sensitivity to these modalities, and rarely either heat or ice can burn or irritate the skin. The result is a temporary increase in skin pain, and there may even be some blistering of the skin. These problems occur so rarely that there are no available statistics to quantify their probability.

Soreness: It is common for chiropractic adjustments, traction, massage therapy, exercises, spinal decompression therapy etc., to result in a temporary increase in soreness in the region being treated. This is nearly always a temporary symptom that occurs while your body is undergoing therapeutic change. It is not dangerous, but please do tell your doctor about it.

Other problems: There may be other problems or complications that might arise from chiropractic treatment other than those noted above. These other problems or complications occur so rarely that it is not possible to anticipate and/or explain them all in advance of treatment.

Chiropractic is a system of health care delivery, and , therefore, as with any health care delivery system we cannot promise a cure for any symptom, disease , or condition as a result of treatment at this office. We will always give you our best care, and if results are not acceptable, we will refer you to another provider who we feel will assist your situation.

Patient initials_____ Date_____

If you have any questions on the above, please ask your doctor. When you have a full understanding, please sign and date below.

I hereby request and consent to the performance of Chiropractic adjustments and other procedures, including various modes of physical therapy, spinal decompression and diagnostic x-rays on me by the doctor of Chiropractic name below and or other doctors of Chiropractic who now and in the future treat me while employed by, work, or associate with serving as back-up for the doctor of Chiropractic named below, including those working at this clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I have read, or have had read to me, the above consent. I have also had the opportunity to ask questions about this consent. And by signing below I agree to the above-named procedures. I intend for this consent form to cover the entire course of treatment for my present condition and for future condition(s) for which I seek treatment.

This consent form was personally reviewed with the patient and any patient questions were answered by Dr.

_____, D.C. on _____

_____ _____

Patients Signature Date

_____ _____

Witness Date

Patient initials_____ Date_____