WELCOME TO SOUTHWEST BACK CLINIC

PATIENT INFORMATION

Date_____

Patient Name_____
Last Name

_____
First Name Middle Initial

SSN_____

Address_____

City_____

State_____ Zip_____

E-mail_____

Sex ☐ M ☐ F Age_____D.O.B_____

☐ Married ☐ Widowed ☐ Single

☐ Seperated ☐ Divorced ☐ Minor

Occupation_____

Patient Employer/School_____

Employer/School Address_____

_____

Employer/School Phone# (____) _____

Spouse's Name_____

Spouse's Employer_____

Whom may we thank for referring you?_____

_____

INSURANCE

Who is responsible for this account?_____

Relationship to Patient_____

Insurance Co._____

Group # _____ ID#_____

Is patient covered by additional insurance? ☐ yes ☐ no

Subscriber's Name_____

D.O.B_____ SSN_____

Relationship to patient_____

Insurance Co._____

Group #_____ ID#_____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to

Dr. Jim Collier and/or Melissa Jones all insurance benefits. If any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian or Personal representative

_____ _____
Date Relationship to Patient

PHONE NUMBERS

Home Phone (____) _____

Cell Phone (____) _____

IN CASE OF EMERGENCY CONTACT

Name_____

Relationship_____

Home Phone (____) _____

Work Phone (____) _____

ACCIDENT INFORMATION

Is this condition due to an accident? ☐ Yes ☐ No

Date_____

Type of accident

☐ Auto ☐ Work ☐ Home ☐ Other

To whom have you made a report of your accident?

☐ Auto Insurance ☐ Employer

☐ Worker's Comp. ☐ Other

Attorney Name (if applicable)

_____

Patient Name_____

History

Reason for Visit:_____

_____

Where did the injury occur: Automobile Work Other:_____

Date of Injury:_____ **Pain Type:** Sharp, dull, achy, throbbing, other_____

Side: Left Right Bilateral **Rate your pain** (0-10):_____ Is this condition getting progressively worse? Yes No

Select frequency you experience pain from this condition: always hourly daily occasionally

Anything that **aggravates** your condition: _____

Anything that **relieves or improves** your condition: _____

Does this condition interfere with any of your daily activities?: No Yes, explain:_____

What treatment have you already recieved for this condition? Medications, Surgery, Physical Therapy, Chiropractic, other: _____

Affected your quality of sleep? No Yes Affected your appetite? No Yes Missed any work due to this injury? No Yes
Have you reduced or limited your work hours because of this condition? No Yes, explain: _____
List other practitioners seen for this injury/ condition: _____
Please list any health conditions that you have been treated for in the last year: (condition, cause, current/resolved): _____
What other health issues are you having or have ever had?_____

_____
What are you allergic to?_____
What surgeries have you had? _____
Circle to indicate if you have or have ever been treated on the past for:

Diabetes	Ulcer/ Reflex	Asthma	Head Injury
Thyroid	Gallbladder	COPD	Hayfever
Anemia	Epilepsy	Other Lung Problems	Bleeding problems
Kidney	Hepatitis	Heart Problems	Depression
Cancer	Arthritis	Angina/ Chest Pain	Mental Illness
Blood Pressure	Glaucoma	Headaches	Suicide Attempts

Circle to indicate your FAMILY HISTORY (mother, father, grandparents, brother, sister)
Heart Disease High Blood Pressure Stroke Cancer Diabetes Kidney Disease Lung Disease
Height: _____ Weight: _____
Exercise: None Moderate Heavy Daily _____ times/ week
Personal Habits: Smoking ____ Packs/ day for ____ years, Alcohol ____ drinks/ week, Caffine ____ cups/ day
High Stress Level? Reason: _____, Other:_____
Are you pregnant (female patients only)? Yes No Due Date?_____
Current Medications/ Vitamins/ Supplements/ Minerals:

Name	Dose	Frequency/Duration	Reason For Medication

Have you been adjusted by a chiropractor before? No Yes, reason for those visits?_____

_____

Acknowledgement for Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of Your Protected Health Information

Your Protected Health Information will be used by Southwest Back Clinic or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. You may review the Notice prior to signing this consent. You may request a copy of the Notice at the Front Desk.

Requesting a Restriction on the Use or Disclosure of Your Information

- You may request a restriction on the use or disclosure of your Protected Health Information.
- This office may or may not agree to restrict the use or disclosure of your Protected Health Information.
- If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards

Revocation of Consent

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

By my signature below I give my permission to use and disclose my health information.

_____

Patient or Legally Authorized Individual Signature Date

_____

Print Patient's Full Name

_____

Witness Signature Date

Informed Consent to Care

SOUTHWEST BACK CLINIC strives to ensure the highest quality care to our patients. All fields of health care are associated with potential risks. In order to provide you with health care services, it is our lawful obligation to ensure you fully understand the potential benefits and risks associated with chiropractic and physical rehabilitation. This is called INFORMED CONSENT OF TREATMENT

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, 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, fractures (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 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 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 and it is estimated to be related to in one in one million to one in two million cervical adjustments.

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.

Printed Name of Patient: _____

Printed name of Guardian/Parent and Relationship to Patient_____

Patient or Parent Signature: X_____ Date: _____