

Patient Name: _____ Date: _____

Address _____ City _____ State _____ Zip Code _____

H. Phone _____ W. Phone _____ Cell Phone _____

Email: _____ Primary Care Physician _____

Social Security _____

Referral Source: Google. Facebook Insurance Referral Personal Referral Doctors Referral

Sex M F Marital Status M S D W Date of Birth _____ Age _____

Occupation _____

Employer _____

Emergency Contact and Phone Number: _____

Referred by: _____

Have you ever received Chiropractic Care? Yes No If yes, when? _____

Name of most recent Chiropractor: _____

1. Past Health History:

A. Surgeries:

Date	Type of Surgery
_____	_____
_____	_____
_____	_____

B. Previous Injury or Trauma: _____

Have you ever broken any bones? Which? _____

C. Allergies: _____

2. Family Health History:

Do you have a family history of? (Please indicate all that apply)

- Cancer Strokes/TIA's Headaches Heart disease Neurological diseases
- Adopted/Unknown Cardiac disease below age 40 Psychiatric disease Diabetes
- Other _____ None of the above

A. Deaths in immediate family:

Cause of parents' or siblings' death	Age at death
_____	_____
_____	_____

3. Social and Occupational History:

A. Job description: _____

Patient Name: _____ Date: _____

B. Work schedule: _____

C. Recreational activities: _____

D. Lifestyle:

Hobbies: _____

Level of Exercise: _____

Alcohol Use: _____

Tobacco Use: _____

Drug Use: _____

Diet: _____

4. Medications:

Medication	Reason for taking
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Review of Systems

Have you had any of the following **pulmonary (lung-related)** issues?

- Asthma/difficulty breathing
- COPD
- Emphysema
- Other _____
- None of the above

Have you had any of the following **cardiovascular (heart-related)** issues or procedures?

- Heart surgeries
- Congestive heart failure
- Murmurs or valvular disease
- Heart attacks/MIs
- Heart disease/problems
- Hypertension
- Pacemaker
- Angina/chest pain
- Irregular heartbeat
- Other _____
- None of the above

Have you had any of the following **neurological (nerve-related)** issues?

- Visual changes/loss of vision
- One-sided weakness of face or body
- History of seizures
- One-sided decreased feeling in the face or body
- Headaches
- Memory loss
- Tremors
- Vertigo
- Loss of sense of smell
- Strokes/TIAs
- Other _____
- None of the above

Have you had any of the following **endocrine (glandular/hormonal)** related issues or procedures?

- Thyroid disease
- Hormone replacement therapy
- Injectable steroid replacements
- Diabetes
- Other _____
- None of the above

Have you had any of the following **renal (kidney-related)** issues or procedures?

- Renal calculi/stones
- Hematuria (blood in the urine)
- Incontinence (can't control)
- Bladder Infections
- Difficulty urinating
- Kidney disease
- Dialysis
- Other _____
- None of the above

Patient Name: _____ Date: _____

Have you had any of the following **gastroenterological (stomach-related)** issues?

- Nausea Difficulty swallowing Ulcerative disease Frequent abdominal pain Hiatal hernia Constipation
- Pancreatic disease Irritable bowel/colitis Hepatitis or liver disease Bloody or black tarry stools
- Vomiting blood Bowel incontinence Gastroesophageal reflux/heartburn Other _____ None of the above

Have you had any of the following **hematological (blood-related)** issues?

- Anemia Regular anti-inflammatory use (Motrin/Ibuprofen/Naproxen/Naprosyn/Aleve) HIV positive
- Abnormal bleeding/bruising Sickle-cell anemia Enlarged lymph nodes Hemophilia
- Hypercoagulation or deep venous thrombosis/history of blood clots Anticoagulant therapy Regular aspirin use
- Other _____ None of the above

Have you had any of the following **dermatological (skin-related)** issues?

- Significant burns Significant rashes Skin grafts Psoriatic disorders Other _____ None of the above

Have you had any of the following **musculoskeletal (bone/muscle-related)** issues?

- Rheumatoid arthritis Gout Osteoarthritis Broken bones Spinal fracture Spinal surgery Joint surgery
- Arthritis (unknown type) Scoliosis Metal implants Other _____ None of the above

Have you had any of the following **psychological** issues?

- Psychiatric diagnosis Depression Suicidal ideations Bipolar disorder Homicidal ideations Schizophrenia
- Psychiatric hospitalizations Other _____ None of the above

Is there anything else in your past medical history that you feel is important to your care here? _____

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of chiropractic to provide me with chiropractic care, in accordance with this state's statutes. If my insurance will be billed, I authorize payment of medical benefits to **Zach Vahldick DC** for services performed.

Patient or Guardian Signature _____ Date _____

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy describes how we may use and disclose your protected health information (PHI) to carry our treatment, payment or health care operations (TPO) for other purposes that are permitted or required by law. "Protected Health Information" is information about you, including demographic information that may identify you and that related to your past, present, or future physical or mental health or condition and related care services.

Use and Disclosures of Protected Health Information:

Your protected health information may be used and disclosed by your physician, our staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, pay your health care bills, to support the operations of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your health care information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Patient Name: _____ **Date:** _____

Healthcare Operations: We may disclose, as needed, your protected health information in order to support the business activities of your physician’s practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing, and fundraising activities, and conduction or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations included as required by law, public health issues, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, and organ donation. Required uses and disclosures under the law, we must make disclosures to you when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES WILL BE MADE ONLY WITH YOUR CONSENT, AUTHORIZATION OR OPPORTUNITY TO OBJECT UNLESS REQUIRED BY LAW.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician’s practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Signature of Patient or Representative

Date

Printed Name

Patient Name: _____ Date: _____

Informed Consent Document

To the Patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The nature of the chiropractic adjustment.

The primary treatment used by doctors of chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible “pop” or “click,” much as you have experienced when you “crack” your knuckles. You may feel a sense of movement.

Analysis/Examination/Treatment

As a part of the analysis, examination, and treatment, you are consenting to the following procedures: ___spinal manipulative therapy ___palpation ___vital signs ___range of motion testing ___orthopedic testing ___basic neurological testing ___muscle strength testing ___postural analysis testing ___graston ___acupuncture/Dry Needling

The risks inherent in chiropractic adjustment.

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. The Doctor will make every reasonable effort during the examination to screen for contraindications to care; however if you have a condition that would otherwise not come to the Doctor’s attention it is your responsibility to inform the Doctor.

The probability of those risks occurring.

Fractures are rare occurrences and generally result from some underlying weakness of the bone which we check for during the taking of your history and during examination and X-ray. Stroke and/or arterial dissection caused by chiropractic manipulation of the neck has been the subject of ongoing medical research and debate. The most current research on the topic is inconclusive as to a specific incident of this complication occurring. If there is a causal relationship at all it is extremely rare and remote. Unfortunately, there is no recognized screening procedure to identify patients with neck pain who are at risk of arterial stroke.

The availability and nature of other treatment options.

Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers
- Hospitalization
- Surgery

If you chose to use one of the above noted “other treatment” options you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated.

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

Patient Name: _____ Date: _____

CONSENT TO TREATMENT (MINOR)

I hereby request and authorize, Dr Zach Vahldick, to perform diagnostic tests and render chiropractic adjustments and other treatment to my minor son/daughter: _____.

As of this date, I have the legal right to select and authorize health care services for the minor child named above. Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or other parent is not required. If my authority to so select and authorize this care should be revoked or modified in any way. I will immediately notify this office.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE. PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW

I have read [] or had read to me [] the above explanation of the chiropractic adjustment and related treatment. I have discussed it with, Dr. Zach Vahldick and have had my questions answered to my satisfaction. By signing below I state that I have weighted the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Dated: _____

Patient's Name _____

Signature _____

Signature of Parent or Guardian (if a minor) _____

Provider signature _____

Patient Name: _____ Date: _____

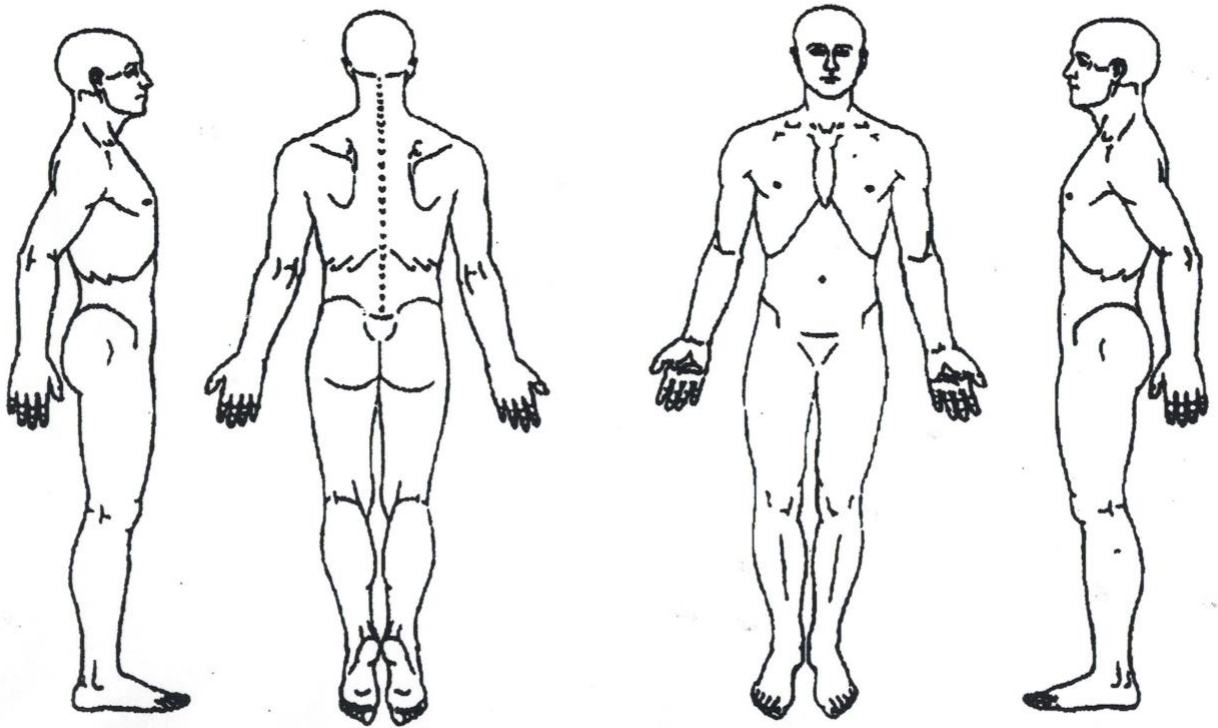
PAIN ASSESSMENT

Name: _____

Date: _____

Shade in all areas of pain. Grade the intensity of pain in each area using 0 - 10 scale:

0 = no pain / no discomfort, 10 = the worst pain you can imagine



Patient Name: _____ Date: _____

NEW PATIENT HISTORY FORM

Symptom _____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- Did the symptom begin suddenly or gradually? (circle one)
- When did the symptom begin? _____
 - How did the symptom begin? _____
- What makes the symptom worse? (circle all that apply):
 - nothing, any movement, bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, driving, standing, walking, running, lifting, sitting, getting up from seated position, chewing, changing positions, lying down, reading, working, exercising, laying on side in bed, other (please describe): _____
- What makes the symptom better? (circle all that apply):
 - nothing, resting, ice, heat, stretching, exercise, walking, pain medication, muscle relaxers, chiropractic adjustments, massage, other (please describe): _____
- Describe the quality of the symptom (circle all that apply):
 - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging
 - Other (please describe): _____
- Does the symptom radiate to another part of your body (circle one): yes no
 - If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (please circle)
 - No difference Morning Afternoon Evening Night Other _____
- Have you received treatment for this condition and episode prior to today's visit?
 - No
 - Anti-inflammatory meds
 - Pain medication
 - Muscle relaxers
 - Trigger point injections
 - Cortisone injections
 - Surgery
 - Massage
 - Physical Therapy
 - Chiropractic
 - Other _____

Patient Name: _____ Date: _____

NEW PATIENT HISTORY FORM

Symptom 2 _____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- Did the symptom begin suddenly or gradually? (circle one)
- When did the symptom begin? _____
 - How did the symptom begin? _____
- What makes the symptom worse? (circle all that apply):
 - nothing, any movement, bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, driving, standing, walking, running, lifting, sitting, getting up from seated position, chewing, changing positions, lying down, reading, working, exercising, laying on side in bed, other (please describe): _____
- What makes the symptom better? (circle all that apply):
 - nothing, resting, ice, heat, stretching, exercise, walking, pain medication, muscle relaxers, chiropractic adjustments, massage, other (please describe): _____
- Describe the quality of the symptom (circle all that apply):
 - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging
 - Other (please describe): _____
- Does the symptom radiate to another part of your body (circle one): yes no
 - If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (please circle)
 - No difference Morning Afternoon Evening Night Other _____
- Have you received treatment for this condition and episode prior to today's visit?
 - No
 - Anti-inflammatory meds
 - Pain medication
 - Muscle relaxers
 - Trigger point injections
 - Cortisone injections
 - Surgery
 - Massage
 - Physical Therapy
 - Chiropractic
 - Other _____

Patient Name: _____ Date: _____

NEW PATIENT HISTORY FORM

Symptom 3 _____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- Did the symptom begin suddenly or gradually? (circle one)
- When did the symptom begin? _____
 - How did the symptom begin? _____
- What makes the symptom worse? (circle all that apply):
 - nothing, any movement, bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, driving, standing, walking, running, lifting, sitting, getting up from seated position, chewing, changing positions, lying down, reading, working, exercising, laying on side in bed, other (please describe): _____
- What makes the symptom better? (circle all that apply):
 - nothing, resting, ice, heat, stretching, exercise, walking, pain medication, muscle relaxers, chiropractic adjustments, massage, other (please describe): _____
- Describe the quality of the symptom (circle all that apply):
 - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging
 - Other (please describe): _____
- Does the symptom radiate to another part of your body (circle one): yes no
 - If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (please circle)
 - No difference Morning Afternoon Evening Night Other _____
- Have you received treatment for this condition and episode prior to today's visit?
 - No
 - Anti-inflammatory meds
 - Pain medication
 - Muscle relaxers
 - Trigger point injections
 - Cortisone injections
 - Surgery
 - Massage
 - Physical Therapy
 - Chiropractic
 - Other _____

Patient Name: _____ Date: _____

NEW PATIENT HISTORY FORM

Symptom 4 _____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- Did the symptom begin suddenly or gradually? (circle one)
- When did the symptom begin? _____
 - How did the symptom begin? _____
- What makes the symptom worse? (circle all that apply):
 - nothing, any movement, bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, driving, standing, walking, running, lifting, sitting, getting up from seated position, chewing, changing positions, lying down, reading, working, exercising, laying on side in bed, other (please describe): _____
- What makes the symptom better? (circle all that apply):
 - nothing, resting, ice, heat, stretching, exercise, walking, pain medication, muscle relaxers, chiropractic adjustments, massage, other (please describe): _____
- Describe the quality of the symptom (circle all that apply):
 - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging
 - Other (please describe): _____
- Does the symptom radiate to another part of your body (circle one): yes no
 - If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (please circle)
 - No difference Morning Afternoon Evening Night Other _____
- Have you received treatment for this condition and episode prior to today's visit?
 - No
 - Anti-inflammatory meds
 - Pain medication
 - Muscle relaxers
 - Trigger point injections
 - Cortisone injections
 - Surgery
 - Massage
 - Physical Therapy
 - Chiropractic
 - Other _____

Patient Name: _____ Date: _____

NEW PATIENT HISTORY FORM

Symptom 5 _____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- Did the symptom begin suddenly or gradually? (circle one)
- When did the symptom begin? _____
 - How did the symptom begin? _____
- What makes the symptom worse? (circle all that apply):
 - nothing, any movement, bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, driving, standing, walking, running, lifting, sitting, getting up from seated position, chewing, changing positions, lying down, reading, working, exercising, laying on side in bed, other (please describe): _____
- What makes the symptom better? (circle all that apply):
 - nothing, resting, ice, heat, stretching, exercise, walking, pain medication, muscle relaxers, chiropractic adjustments, massage, other (please describe): _____
- Describe the quality of the symptom (circle all that apply):
 - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging
 - Other (please describe): _____
- Does the symptom radiate to another part of your body (circle one): yes no
 - If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (please circle)
 - No difference Morning Afternoon Evening Night Other _____
- Have you received treatment for this condition and episode prior to today's visit?
 - No
 - Anti-inflammatory meds
 - Pain medication
 - Muscle relaxers
 - Trigger point injections
 - Cortisone injections
 - Surgery
 - Massage
 - Physical Therapy
 - Chiropractic
 - Other _____

Patient Name: _____ Date: _____

NEW PATIENT HISTORY FORM

Symptom 6 _____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- Did the symptom begin suddenly or gradually? (circle one)
- When did the symptom begin? _____
 - How did the symptom begin? _____
- What makes the symptom worse? (circle all that apply):
 - nothing, any movement, bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, driving, standing, walking, running, lifting, sitting, getting up from seated position, chewing, changing positions, lying down, reading, working, exercising, laying on side in bed, other (please describe): _____
- What makes the symptom better? (circle all that apply):
 - nothing, resting, ice, heat, stretching, exercise, walking, pain medication, muscle relaxers, chiropractic adjustments, massage, other (please describe): _____
- Describe the quality of the symptom (circle all that apply):
 - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging
 - Other (please describe): _____
- Does the symptom radiate to another part of your body (circle one): yes no
 - If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (please circle)
 - No difference Morning Afternoon Evening Night Other _____
- Have you received treatment for this condition and episode prior to today's visit?
 - No
 - Anti-inflammatory meds
 - Pain medication
 - Muscle relaxers
 - Trigger point injections
 - Cortisone injections
 - Surgery
 - Massage
 - Physical Therapy
 - Chiropractic
 - Other _____