PATIENT NAME _____

SSN: _____ DATE _____

ADDRESS: _____
Street City State Zip

Date of Birth: _____ Age: _____: Sex: Male _____ Female _____ Other: ___

Home #: _____ Work #: _____ Cell #: _____

Email: _____

Occupation: _____

Relationship status: _____ Spouse/Partner Name: _____

Emergency contact: _____
Name Relationship Phone #

CONSULTATION QUESTIONNAIRE

1. What is your major symptom? _____

2. If this is a recurrence, when was the first time you noticed this problem?_____
   How did it originally occur?_____
   Has it become worse recently? Yes ___ No ___ Same ___ Better ___ Gradually Worse _____
   If yes, when and how? _____

3. How frequent is the condition? Constant _____ Daily ____ Intermittent ____ Night Only ___
   How long does it last? All Day _____ Few Hours _____ Minutes _____

4. Are there any other conditions or symptoms that may be related to your major symptom?
   Yes _____ No _____. If yes, describe: _____
   Are there other unrelated health problems? Yes _____ No _____. If yes, describe _____
   _____

5. Describe the pain: Sharp _____ Dull_____ Numbness _____ Tingling _____ Aching _____
   Burning _____ Stabbing _____ Other _____

6. Is there anything you can do to relieve the problem? Yes ___ No ___. If yes, describe _____
   _____. If no, what have you tried to do that has not helped? _____
   _____

7. What makes the problem worse? Standing _____ Sitting _____ Laying _____ Bending _____

8. What does this prevent you from doing or enjoying?_____
   _____

9. List any major accidents you have had other than those that might be mentioned above: _____
   _____

10. WOMEN ONLY: Are you pregnant or is there any possibility you may be pregnant?
    Yes _____ No _____ Uncertain _____

11. Please list any over the counter medications or supplements: _____
    _____

12. History of surgeries, illness, or hospitalization: _____

Do you have or have you had the following conditions?

☐High/Low Blood Pressure	☐Glaucoma	☐Bleeding Disorders	☐Problems Urinating
☐Heart Attack	☐Emphysema	☐Diabetes	☐High Cholesterol
☐Stroke	☐HIV/AIDS	☐Dizziness	☐Asthma
☐Headaches	☐Tuberculosis	☐Nausea	☐Tinnitus
☐Cancer	☐Hepatitis	☐Vomiting	☐Liver Problems
☐Blurred Vision	☐Kidney disease	☐Diarrhea	
	☐Hernias		

I _____ affirm the above statement is true to the best of my knowledge:

Patient's Signature _____ Date _____

Billing and Cancellation Policy

L-evated Chiropractic takes payment at the time services are rendered. If you have insurance our staff will bill the insurance company, we are in network with and apply the applicable charge to your office visit. If L-elevated Chiropractic is not in network with your insurance, we are happy to provide you with an itemized statement for you to bill your insurance company on your own. It is the patient's responsibility to pay their total cost of the visit at the time of service.

Initials: _____

Patient's must provide a **24-hour notice** if needing to cancel or change any appointment. The patient will be charged a **$25.00 fee** for each missed appointment. After 3 missed appointments the patient and doctor will discuss the reasons for missing the appointments and decide whether the patient should be released from care or continue care at L-evated Chiropractic.

Initial: _____

Print Name: _____

Signature: _____

Parent/Guardian Signature: _____ Date: _____

INFORMED CONSENT

PATIENT NAME _____

I will use my hands or a mechanical instrument upon your body in such a way as to move your joints. This procedure is referred to as ”Spinal Manipulation” or Spinal Adjustment” As the joints in your spine are moved, you may experience a “pop” as part of the process..

Clinicians who use spinal manual therapy techniques, such as for example joint adjustment or manipulation or mobilization, are required to inform patients that there are or may be some risks associated with such treatment. In particular: -

a) While rare, some patients have experienced muscle and ligament sprains or strains, or rib fractures following spinal manual therapy.
b) There have been reported cases of injury to a vertebral artery following neck adjustment, manipulation and mobilization. Such vertebral artery injuries may on rare occasion cause stroke, which may result in serious neurological injury and/or physical impairment. This form of complication is an extremely rare event, occurring about 1 time per 1 million treatments.
c) There have been reported cases of disc injuries following spinal manual therapy, although no scientific study has ever demonstrated that such injuries are caused, or may be caused, by adjustment or manipulative techniques and such cases are also very rare.
Treatments provided at this clinic, including spinal adjustment, manipulation and /or mobilization, have been the subject of much research conducted over many years and have been demonstrated to be appropriate and effective treatments for many common forms of spinal pain, pain in the shoulders/arms/legs, headaches and other similar symptoms. Treatment provided at this clinic may also contribute to your overall wellbeing. The risk of injury or complication from manual treatment is substantially lower than the risk associated with many medications, other treatments and procedures frequently given as alternative treatments for the same forms of musculoskeletal pain and other associated syndromes.

There are certain complications that can occur as a result of a spinal manipulation. These compilations include, but are not limited to: muscle strain, cervical myelopathy, disc and vertebral injury, fractures, strains and dislocations, Bernard-Horner’s Syndrome (also known as oculosympathethetic palsy), costovertebral strains and separation. Rare complications include but are not limited to stroke. The most common complication or complaint following spinal manipulation is an ache or stiffness at the site of adjustment.

I am aware of these complications, and in order to minimize their occurrence I will take precautions. These precautions include but are not limited to my taking a detailed clinical history of you and examining you for any defect which would cause a complication. This examination may include the use of x-rays. The use of x-ray equipment may pose a risk if you are pregnant. If you are pregnant, you should tell me when I take you clinical history.

DATE _____

_____
Printed Name

_____
Signature

_____
Signature of Parent or Guardian (if a minor)

HIPAA Release of information
AUTHORIZATION FORM

I, _____hereby authorize L-evated Chiropractic, affiliates, and its employees to release all my medical records to _____ [Insert full name of person/organization], except the following information about me: _____ [DESCRIBE INFORMATION NOT TO BE DISCLOSED, IF ANY]. I understand that any personal health information or other information released to the person or organization identified above may be subject to re-disclosure by such person/organization and may no longer be protected by applicable federal and state privacy laws. This authorization is valid for one year from the date of my/my representative's signature below. I understand that I have a right to revoke this authorization by providing written notice to L-evated Chiropractic. However, this authorization may not be revoked if L-evated Chiropractic, has already taken action on this authorization prior to receiving my written notice. I also understand that I have a right to have a copy of this authorization. I further understand that this authorization is voluntary and that I may refuse to sign this authorization.

I, _____hereby authorize L-evated Chiropractic, affiliates, and its employees to share any information regarding my medical treatment, including records to the following individuals:

Name:_____ Relationship:_____

Name: _____ Relationship:_____

Name:_____ Relationship:_____

I,_____ understand that my personal information, and medical records are kept confidential from any and all persons unless I allow L-evated Chiropractic to release any information. I also understand that L-evated Chiropractic has 7 business days after this form is signed to completely release any records requested. Additional fees may be charged to my account for files larger than 50 sheets to cover paper and ink not to exceed $0.03 per page. If records are being mailed, I may also be charged postage by L-evated Chiropractic if they choose to do so.

Print Name: _____

Signature:_____ Date:_____

Parent or Guardian Signature:_____