APPLICATION FOR CARE AT THOMPSON VALLEY CHIROPRACTIC

Today's Date: _____

PATIENT DEMOGRAPHICS

Name: _____ Prefer To Be Named: _____ DOB: ____-____-____ ☐ Male ☐ Female

Address: _____ City: _____ State: _____ Zip: _____

E-mail Address: _____ Home Phone: _____Mobile Phone:_____

Work Phone: _____ Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Insurance: ☐ Yes ☐ No Social Security #: _____

Employer: _____ Occupation: _____

Spouse's Name _____ Spouse's Employer _____

Children's names and ages: _____

Name & Number of Emergency Contact: _____Relationship: _____

Whom may we give a THANK YOU for referring you to this office? _____

HISTORY OF COMPLAINT

Please identify the condition(s) that brought you to this office: _____

_____ _____

When did the condition(s) begin?

_____

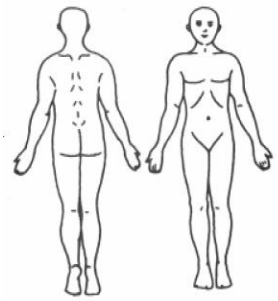
How did the conditions(s) happen?

_____

Is your problem the result of ANY type of accident? ☐ Yes, ☐ No

PLEASE MARK the areas on the Diagram with the following **letters** to describe your symptoms:

R = Radiating **B = B**urning **D = D**ull **A =** Aching **N = N**umbness **S = S**harp/**S**tabbing **T = T**ingling



What relieves your symptoms? _____

What makes your symptoms feel worse? _____

What concerns you the most about your condition?_____

_____

LIST RESTRICTED ACTIVITY:	CURRENT ACTIVITY LEVEL	DESIRED ACTIVITY LEVEL
_____: →	_____	_____
_____: →	_____	_____
_____: →	_____	_____
_____: →	_____	_____

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PAST HISTORY

If you have ever been diagnosed with any of the following conditions, please indicate with a **P** for in the ***Past***, **C** for ***Currently*** have or **N** for ***Never*** have had**:**

___ Concussion ___Dislocations ___ Tumors ___Rheumatoid Arthritis ___ Fracture ___Disability ___Cancer
___ Heart Attack ___Osteo Arthritis ___ Diabetes ___Stroke/TIA ___ Other serious conditions: _____

PLEASE IDENTIFY ALL PAST and any **CURRENT** conditions you feel may be contributing to your present problem:

	HOW LONG AGO	TYPE OF CARE RECEIVED	BY WHOM
INJURIES →			
SURGERIES →			
CHILDHOOD DISEASE →			

SOCIAL HISTORY

1. Smoking: ☐cigars ☐ pipe ☐ cigarettes How often? ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never
2. Alcoholic Beverage: consumption occurs ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never
3. Recreational Drug use: ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never
4. Hobbies -Recreational Activities- Exercise Regime: How does your present problem affect? (See Activities of life form)

FAMILY HISTORY

1. Does anyone in your family suffer with the same condition(s)? ☐ No ☐ Yes
If yes whom: ☐ grandmother ☐ grandfather ☐ mother ☐ father ☐ sister(s) ☐ brother(s) ☐ son(s) ☐ daughter(s)
Have they ever been treated for their condition? ☐ No ☐ Yes ☐ I don't know
2. Any other hereditary conditions the doctor should be aware of? ☐ No ☐ Yes: _____

REVIEW OF SYSTEMS

Past	Present		Past	Present		Past	Present	
☐	☐	Jaw Pain, TMJ	☐	☐	Heart Problems	☐	☐	Kidney Problems
☐	☐	Neck Pain	☐	☐	High Blood Pressure	☐	☐	Excessive Thirst
☐	☐	Upper Back Pain	☐	☐	Low Blood Pressure	☐	☐	Painful Urination
☐	☐	Mid Back Pain	☐	☐	Sexual Dysfunction	☐	☐	Frequent Urination
☐	☐	Low Back Pain	☐	☐	Convulsions/Epilepsy	☐	☐	Bladder Infection
☐	☐	Shoulder Pain	☐	☐	Tremors	☐	☐	Liver Trouble
☐	☐	Elbow/Arm Pain	☐	☐	Depression	☐	☐	Hepatitis (A, B, C)
☐	☐	Hip Pain	☐	☐	ADD/ADHD	☐	☐	Gall Bladder Trouble
☐	☐	Leg Pain	☐	☐	Mood Changes	☐	☐	Digestive Problems
☐	☐	Knee Pain	☐	☐	Irritable	☐	☐	Heartburn
☐	☐	Ankle/Foot Problems	☐	☐	Trouble Sleeping	☐	☐	Ulcers
☐	☐	Chest Pain	☐	☐	Dizziness	☐	☐	Colon Problems
☐	☐	Abdominal Pain	☐	☐	Allergies	☐	☐	Diarrhea
☐	☐	Joint Pain/Stiffness	☐	☐	Fainting	☐	☐	Constipation
☐	☐	Headaches	☐	☐	Loss of Balance	☐	☐	Prostate Problems
☐	☐	Migraines	☐	☐	Double Vision	☐	☐	Impotence
☐	☐	Skin Problems	☐	☐	Blurred Vision	☐	☐	Asthma
☐	☐	Hearing Loss	☐	☐	Bed Wetting	☐	☐	Lung Problems
☐	☐	Ringing in ears	☐	☐	General Fatigue	☐	☐	Sinus Problems
☐	☐	Menopausal Problems	☐	☐	PMS	☐	☐	Menstrual Problems

Patient/Authorized Signature: _____ Date:_____

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ACTIVITIES OF LIFE

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

ACTIVITIES:	EFFECT:			
Carry Children/Groceries	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sit to Stand	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Climb Stairs	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Pet Care	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Extended Computer Use	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Lift Children/Groceries	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Read/Concentrate	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Getting Dressed	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Shaving	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sexual Activities	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sleep	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Static Sitting	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Static Standing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Yard work	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Walking	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Washing/Bathing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sweeping/Vacuuming	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Dishes	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Laundry	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Garbage	☐ No Effect	☐ Painful (can do)	☐ Painful (limits	☐ Unable to Perform
Driving	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Other: _____	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform

List Prescription & Non-Prescription drugs you take: _____

_____

_____

_____

_____

Patient/Authorized Signature: _____ Date:_____

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Informed Consent

REGARDING: Chiropractic Adjustments, Modalities, and Therapeutic Procedures:

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 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 an "arterial dissection" that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis. Arterial dissections occur 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. The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events/ per one million persons/year and risk of death has been estimated as 104 per one million users.
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.

Patient Name: _____ Signature: _____ Date:_____

Parent or Guardian: _____ Signature: _____ Date: _____

Witness Name: _____ Signature: _____ Date: _____

NOTICE OF PRIVACY PRACTICE

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your **P**ersonal **H**ealth **I**nformation. In addition we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as **dictated by our office policy,** we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. Once you have read this notice, please sign the last page, and return only the signature page (page 2) to our front desk receptionist. Keep this page for your records.

PERMITTED DISCLOSURES:

1. Treatment purposes - discussion with other health care providers involved in your care.
2. Inadvertent disclosures - open treating area mean open discussion. If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room.
3. For payment purposes - to obtain payment from your insurance company or any other collateral source.
4. For workers compensation purposes - to process a claim or aid in investigation.
5. Emergency - in the event of a medical emergency we may notify a family member.
6. For Public health and safety - in order to prevent or lessen a serious or eminent threat to the health or safety of a person or general public.
7. To Government agencies or Law enforcement - to identify or locate a suspect, fugitive, material witness or missing person.
8. For military, national security, prisoner and government benefits purposes.
9. Deceased persons - discussion with coroners and medical examiners in the event of a patient's death.
10. Telephone calls or emails and appointment reminders - **we may call or text your phone number and leave messages** regarding a missed appointment or apprize you of changes in practice hours or upcoming events.
11. Change of ownership- in the event this practice is sold, the new owners would have access to your PHI.

YOUR RIGHTS:

1. To receive an accounting of disclosures.
2. To receive a paper copy of the comprehensive "Detail" Privacy Notice.
3. To request mailings to an address different than residence.
4. To request Restrictions on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction.
5. To inspect your records and receive one copy of your records at no charge, with notice in advance.
6. To request amendments to information. However, like restrictions, we are not required to agree to them.
7. To obtain **one copy** of your records at no charge, when timely notice is provided (72 hours). **X-rays** are original records and you are therefore not entitled to them. If you would like us to outsource them to an imaging center, to have copies made, we will be happy to accommodate you. However, you will be responsible for this cost.

COMPLAINTS:

If you wish to make a formal complaint about how we handle your health information, please call Dr. Becky at 970-203-0597. If she is unavailable, you may make an appointment with our receptionist to see her within 72 hours or 3 working days. If you are still not satisfied with the way this office handles your complaint, you can submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Ave. SW
Room 509F HHH Building
Washington DC 20201

Patient initials: **_____-retaining *page 1 of 2***

May we discuss your medical condition with any member of your family? Yes / No

If YES, please name the members allowed:

_____

_____

_____

_____

_____

_____

Thompson Valley Chiropractic NOTICE REGARDING YOUR RIGHT TO PRIVACY continued…

I have received a copy of Thompson Valley Chiropractic Patient Privacy Notice. I understand my rights as well as the practice's duty to protect my health information and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this "Notice of Privacy Practice" at a time in the future and will make the new provisions effective for all information that it maintains past and present.

I am aware that a more comprehensive version of this "Notice" is available to me and several copies kept in the reception area. At this time, I do not have any questions regarding my rights or any of the information I have received.

_____ _____
Patient's Printed Name DOB

_____ _____
Patient's Signature Date

_____ _____
Witness Date

REGARDING: X-rays/Imaging Studies

By my signature below I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

_____ ____/____/____ ☐ ***Witness Initials***

Patient or Authorized Person's Signature Date

FEMALES ONLY → *please read carefully and check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our receptionist for further explanation.*

☐ The first day of my last menstrual cycle was on ____-____-____ (Date)

☐ I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant.

REGARDING: Financial Responsibility and Agreement

I hereby authorize payment to be made directly to Thompson Valley Chiropractic, for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Thompson Valley Chiropractic for any and all services I receive at this office. I understand that there will be a monthly $30 late fee for any balance due past 30 days. I understand that if I cancel my massage appointment within 24 hours that there will be a missed appointment fee of $30 applied to my account.

_____ _____ - _____ - _____

Patient or Authorized Person's Signature **Date Completed**

_____ _____ - _____ - _____

Doctor's Signature **Date Form Reviewed**

AUTOMOBILE/PI ACCIDENT OR WORK COMP QUESTIONNAIRE

Patient's Name	Date of Birth	Date

This information is considered confidential. Your answers will help us determine if chiropractic care can help your condition. We will not accept your case if we do not believe your condition will respond satisfactorily to care. In order for us to understand your condition properly, please be as neat and accurate as possible while completing this form.
Thank you.

Please answer all questions completely by filling in the blank and circling the options listed below

What were the time and date of accident? _____

What state did the accident occur in? _____

What city did the accident occur in? _____

How many vehicles were involved in the accident? _____

What type of vehicle were you in? _____

What was the estimated damage to the vehicle you were in? _____

What was damaged in your vehicle? (Circle all that apply)

-windshield	-rear bumper	-mirror
-steering wheel	-front bumper	-knee bolster
-dashboard	-trunk	-back right door
-seat frame	-front left door	-completely totaled
-side window	-front right door	Other:_____
-rear window	-back left door	Other:_____

Signature:_____

Choose the items that dented inward

-floorboards -side door -dashboard

-Other:_____

Choose the doors that would not open as a result of the accident:

-front left -front right -rear left -rear right

What kind of headrest was in your vehicle?

-movable fixed headrest -non-movable fixed headrest -no headrest

Where was the headrest positioned on your head? _____

What type of vehicle impacted yours? _____

You were heading North/ East/ South/ West on _____ (street or highway)

At the time of impact, how fast was your vehicle moving? _____

Other vehicle was heading North/ East/ South/ West on _____ (street or highway)

At the time of impact, how fast was the other vehicle moving? _____

You were struck from Behind/ Front/ Left Side/ Right Side / Other: _____

You were Driver / Passenger / Front seat/ Back Seat/_____

Did you have your seat belt on during the accident? □No □Yes

Did you slide out of your seatbelt during the accident? □No □Yes

Did your vehicle hit anything after the accident? □No □Yes. If yes, please describe:

_____

During and after the crash what happened to your vehicle? (Circle all that apply)

-kept going straight -spun around

-kept going straight hitting a car in front -spun around and hit a stationery object

-was hit by another vehicle -hit a stationery object

Did you know the accident was coming? ☐ Yes ☐ No

Patient's Name	Signature	Date of Birth	Date

Were you knocked unconscious? ☐ Yes ☐ No If yes, for how long? _____

How was your head positioned during the accident? _____

How was your torso positioned during the accident? _____

How were your hands positioned during the accident? _____

Did your head hit anything during the accident? □No □Yes, please describe:

_____

Did your face hit anything during the accident? □No □Yes, please describe:

_____

Did your shoulders hit anything during the accident? □No □Yes, please describe:

_____

Did your neck hit anything during the accident? □No □Yes, please describe:

_____

Did your chest hit anything during the accident? □No □Yes, please describe:

_____

Did your hips hit anything during the accident? □No □Yes, please describe:

_____

Did your knees hit anything during the accident? □No □Yes, please describe:

_____

Did your feet hit anything during the accident? □No □Yes, please describe:

_____

Where did you feel pain immediately after the accident? _____

_____

List the extent of your injuries as you know them:

_____

_____

_____

_____

Were police notified? ☐ Yes ☐ No If yes, do you have the police report? ☐ Yes ☐ No

Where were you taken after the accident? _____

Were you hospitalized? ☐ Yes ☐ No If yes, admitted? _____ How long? _____

If yes, please complete the following questions (1-7 below)

1. How did you get to the hospital? _____
2. What was the name of the hospital?_____
3. Name of hospital doctor(s): _____
4. Circle what you were prescribed at the hospital:
   a. -pain medication -muscle relaxers -neck brace
   b. Other: _____
5. Did you receive any stitches or staples for any cuts at the hospital? □No □Yes
6. Were x-rays taken at the hospital? □No □Yes If yes, which are was taken?

   _____
7. What treatment was given? _____

Patient's Name	Signature	Date of Birth	Date

Was any other doctor consulted after your accident? ☐ Yes ☐ No

If so, what was the doctor's name?

_____ D.C., M.D., D.O., D.D.S.

What was the diagnosis?

_____

What treatment was given?

_____

How often did you see the doctor?

_____

How long did you see the doctor?

_____

Before the injury were you capable of working on an equal basis with others your age?

☐ Yes ☐ No

Are your work activities restricted as a result of this accident? ☐ Yes ☐ No

Since this injury are your symptoms … ☐ Improving? ☐ Getting worse? ☐ Same

Patient Signature _____Date _____

Doctor Signature _____ Date _____