Riverview Chiropractic Clinic
3505 8th St S Suite 6 • Moorhead MN 56560
218.236.1516 www.riverviewchiromoorhead.com

PATIENT INFORMATION

Please complete the following forms to the best of your knowledge. If you have any questions or concerns, please do not hesitate to ask for assistance. We will be happy to help you.

Patient's Full Name: ______________________________ **Today's Date:** _____/_______/______

Address: ______________________________ **City:** ______________________ **State:** ______ **Zip:** ________

Home Phone: _______________________ **Work Phone:** _______________________ **Cell:** _______________________

Birth Date: ___________________ **Social Security Number:** ______-_____-______ ______**Female** ______**Male**

Are You: ____ a Minor ____Single ____Married ____ Other:______________

E-Mail Address: ______________________________ **E-Statement Consent:** ________ **Yes** ________**No**

By providing your email and selecting e-statements, you agree to receive all billing electronically via email. You will no longer receive paper statements. You may opt out at any time by contacting our office

May we contact you for appointment reminders via text message: ______**Yes** _______ **No**

Cell Phone: ______________________________

Your standard text messaging rates apply in accordance with your current phone provider

Your Employer: ______________________________ **Occupation:** ______________________________

Employer Address: ______________________________**City:**_____________________**State:**______ **Zip:** _________

Spouse's Name: ___________________________ **Workplace:**______________________ **Work Phone:** ______________

Mother's Name: ___________________________**Workplace:**______________________ **Work Phone:** _______________
(If a minor)

Father's Name: ___________________________ **Workplace:**______________________ **Work Phone:** ______________
(If a minor)

Emergency Contact: ______________________________ **Phone #:** ____________________________

How did you hear about us: ___Internet Search ___ Location ___Current Patient Name: ___________________________
Other: ____

Race (circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian)
Native Hawaiian or Pacific Islander / Other / I Decline to Answer

Ethnicity (circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to answer

Preferred Language: ______________________

Thank you for choosing our practice for your chiropractic needs.

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CHIROPRACTIC INFORMED CONSENT FOR DIAGNOSIS AND TREATMENT

I hereby give my consent to the performance of diagnostic tests and procedures and chiropractic treatment or management of my condition(s).

Chiropractic treatment or management of conditions almost always includes the chiropractic adjustment, physiotherapies, and soft tissue therapies. Like most health care procedures, the therapies carry with them some risks. Unlike many such procedures, the serious risks associated with the therapies are extremely rare. Following are the known risks:

Temporary soreness or increased symptoms or pain. It is not uncommon for patients to experience temporary soreness or increased symptoms or pain after the first few treatments.

Dizziness, nausea, flushing. These symptoms are relatively rare. It is important to notify the chiropractor if you experience these symptoms during or after your care.

Fractures. When patients have underlying conditions that weaken bones, like osteoporosis, they may be susceptible to fracture. It is important to notify your chiropractor if you have been diagnosed with a bone weakening disease or condition. If your chiropractor detects any such condition while you are under care, you will be informed and your treatment plan will be modified to minimize risk of fracture.

Disc herniation or prolapse. Spinal disc conditions like bulges or herniations may worsen even with chiropractic care. It is important to notify your chiropractor if symptoms change or worsen.

Stroke. Previous research has suggested an association between cervical spine manipulation and stroke on extremely rare occasions. According to the most recent research, the risk of stroke with chiropractic care is the same as that associated with other types of treatment.

Other risks associated with chiropractic treatment include rare burns from physiotherapy devices that produce heat.

I understand that the practice of chiropractic, like the practice of all healing arts, is not an exact science, and I acknowledge that no guarantee can be given as to the results or outcome of my care.

I have read or had read to me this informed consent document. I have discussed or been given the opportunity to discuss any questions or concerns with my chiropractor and have had these answered to my satisfaction prior to my signing this informed consent document. I have made my decision voluntarily and freely.

_______________________________ _______/_________/__________

Signature of Patient or Guardian **Date**

OFFICE USE ONLY
Based on my personal observation and the patient's history and physical exam, I conclude that throughout the informed consent process the patient was:

[ ] Of legal age
[ ] Appears unimpaired
[ ] Oriented x3
[ ] Fluent in English
[ ] Consent given through Guardian
[ ] Assisted by a translator or interpreter

____
Signature of Translator or Interpreter, if applicable

__________________________ D.C. ________________
Signature of Chiropractor Date

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PATIENT HEALTH QUESTIONNAIRE

Patient Name:______________________________ **Date:** ____/____/____

1. **Describe your symptom(s):** ______________________________

   ____

   a. When did your symptom(s) begin?: ____________________ **Date of onset?:** __________

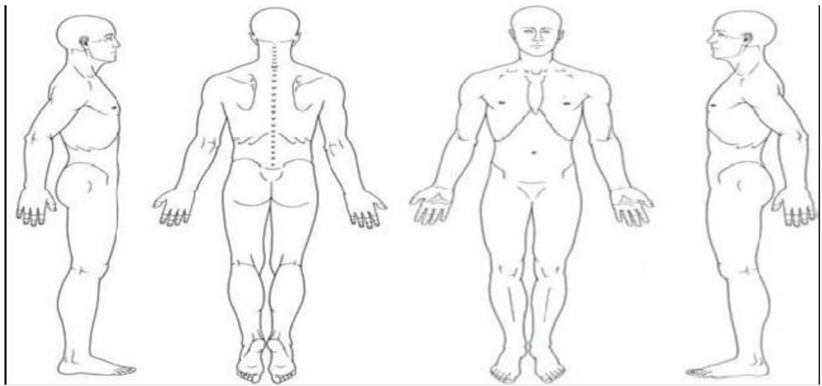
   b. How did your symptom(s) begin?: ______________________________

2. **How often do you experience your symptoms?:**

   ☐ Constantly (76-100% of the day) ☐ Frequently (51-75% of the day)

   ☐ Occasionally (26-50% of the day) ☐ Intermittently (0-25% of the day)

Indicate where you have pain or other symptoms



3. **What describes the nature of your symptoms?:**

   1 Sharp 2 Dull Ache 3 Numb

   4 Shooting 5 Burning 6 Tingling

4. **How are your symptoms changing?**

   ☐ Getting Better

   ☐ Not Changing

   ☐ Getting Worse

5. **Average pain intensity:**

   Last 24 hours: **no pain** 0 1 2 3 4 5 6 7 8 9 10 **unbearable pain**

   Past 4 weeks: **no pain** 0 1 2 3 4 5 6 7 8 9 10 **unbearable pain**

6. **During the <u>past 4 weeks</u> how much of the time has your condition interfered with your usual daily activities?:**
   (including both work outside the home and housework, etc.)

   ☐ All of the time ☐ Most of the time ☐ Some of the time ☐ Quite a bit ☐ None of the time

7. **In general would you say your overall health right now is…..**

   ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

8. **Who have you seen for your symptoms?:** ☐ No One ☐ Medical Doctor ☐ Other Chiropractor

   ☐ Physical Therapist ☐ Other: __________

   a. If so, what treatment did you receive and when?: ______________________________

   b. If any, what tests have you had for your symptoms and when were they performed?: ☐ X-Rays **date:** ________ ☐ CT Scan **date:**________

   ☐ MRI **date:** ________ ☐ Other **date:** ________

9. **Have you had similar symptoms in the past?** ☐ Yes ☐ No

   a. If you have received treatment in the past for the same or similar symptoms, who did you see? ☐ This office ☐ Other Chiropractor ☐ Medical Doctor ☐ Physical Therapist ☐ Other: __________

Patient Signature: ______________________________ **Date:** ____/____/____

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PATIENT HEALTH QUESTIONNAIRE-2

Patient Name: ____ **Date:** ____/______/________

What type of regular exercise do you perform?: ☐ None ☐ Light ☐ Moderate ☐ Strenuous **Height:** ___Ft ___ In **Weight:** ______lbs

For each condition below, check if you have had it in the past and/or in the present.

Past / Present		Past / Present		Past / Present	
☐	☐ Headache	☐	☐ Visual Disturbance	☐	☐ Asthma
☐	☐ Neck Pain	☐	☐ Dizziness	☐	☐ Chronic Sinusitis
☐	☐ Upper Back Pain	☐	☐ High Blood Pressure	☐	☐ Diabetes
☐	☐ Mid Back Pain	☐	☐ Heart Attack	☐	☐ Excessive Thirst
☐	☐ Low Back Pain	☐	☐ Chest Pain	☐	☐ Frequent Urination
☐	☐ Shoulder Pain	☐	☐ Stroke	☐	☐ Drug/Alcohol Dependence
☐	☐ Elbow/Upper Arm Pain	☐	☐ IBS or Crohn's Disease	☐	☐ Depression
☐	☐ Wrist Pain	☐	☐ Kidney Stones	☐	☐ Systemic Lupus
☐	☐ Hand Pain	☐	☐ Kidney Disorder	☐	☐ Epilepsy
☐	☐ Hip/Upper Leg Pain	☐	☐ Bladder Infection	☐	☐ Dermatitis/Eczema/Rash
☐	☐ Knee/ Lower Leg Pain	☐	☐ Painful Urination	☐	☐ HIV/AIDS
☐	☐ Ankle/Foot Pain	☐	☐ Loss of Bladder Control		**Other Health Problems**
☐	☐ Jaw Pain	☐	☐ Abdominal Pain	☐	☐
☐	☐ Joint Swelling/Stiffness	☐	☐ Ulcer	☐	☐
☐	☐ Arthritis	☐	☐ Hepatitis		**Females Only**
☐	☐ Rheumatoid Arthritis	☐	☐ Liver/Bladder Disorder	☐	☐ Birth Control
☐	☐ General Fatigue	☐	☐ Cancer	☐	☐ Hormone Replacement
☐	☐ Muscle Un-coordination	☐	☐ Tumor	☐	☐ Pregnancy

Tobacco use: ☐ Never Smoked ☐ Former Smoker, quit: ________ ☐ Occasional Smoker ☐Every day Smoker
☐ Chewing Tobacco

Indicate if an immediate family member has had any of the following:
☐Rheumatoid Arthritis ☐Heart Problems ☐Diabetes ☐Cancer ☐Lupus ☐ ________________

List all prescriptions, over-the-counter medications, and nutritional/herbal supplements you are taking currently:

____

____

List all known Allergies:

____

____

List all surgical procedures you have had and times you have been hospitalized:

____

____

Patient Signature: ____ **Date:** _____/_______/__________

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PATIENT HEALTH INFORMATION CONSENT FORM

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health information we encourage you to read the HIPAA NOTICE that is given to you before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to use by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance company(ies) require for payment.

2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. *Our office is not obligated to agree to those restrictions.*

3. A patient's written consent need only be obtained one time for all subsequent care given to the patient in this office.

4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to written request to revoke consent but would apply to any care given after the request has been presented.

5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.

6. Patient's have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.

7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

_______________________________________ _______________________________________
Name of Individual (Printed) Signature of Individual

_______________________________________ _______________________________________
Signature of Legal Representative Relationship
(e.g. Attorney-In-Fact, Guardian, Parent if a minor)

Date Signed ______/ ______/ ______ Witness: _______________________________