Schreiber Family CHIROPRACTIC

Chiropractic Patient Information

Patient Name_____ Date of Birth: _____ Age: ____

Local Address: _____ City: _____State: _____Zip:_____

E-mail:_____

Phone #s: Home: _____Work: _____Cell: _____
(Circle Primary)

Text Reminders: YES NO Cell Provider: _____ (ex: Verizon)

Which is the best daytime phone number to reach you? *Home Cell Work*

Marital Status: *Married/Single/Widowed* Spouse's Name: _____ Date of Birth (for Insurance purposes)_____

Student Status: *Full Time Part Time* Name of School: _____

Current/Former Occupation: _____ Retired F/T P/T How long in position? _____

Current Employer: _____ Employer's Phone #:_____

Guardian/Emergency contact info:

Name: _____Relationship: _____Phone Number: _____

How did you hear about our clinic? _____

Have you been treated by a chiropractor before? YES NO When was your last visit? _____

What brought you here today (ex: low back pain)? _____

Patient or Guardian Signature: _____ **Date:** _____

"Let Our Family Take Care Of Your Family."

Notice of Privacy Practice

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.

The health information that you provide to us is needed for several reasons. First, it aids Dr. Bailey or Dr. Schreiber in the treatment and diagnosis of the condition that you have presented with. Second, this data may be used to file insurance claims to receive payment for services rendered. Finally, at times we share this information with third parties (i.e. lawyers, other physicians or your insurance company) in coordination of you care.
Whenever possible our office will get your permission before we disclose your health data with any other third party. Other times we may not be able to obtain your authorization prior to disclosure. Examples may be faxing/sending notes to physicians regarding upcoming appointments, filing medical claims or mailing requested forms/data to your insurance company. We will only correspond with attorneys, workers' compensation or auto insurance companies if we have received a written release of records signed by you, the patient, allowing it.

All information that you provide to us is personal and protected. We do not indiscriminately share this data and any other use not already listed will be made only with the patient's authorization. You as the patient have the right to revoke that authorization at any time.

Patient Rights

1. You may request certain restrictions on the uses/disclosures of protected information.
2. You have the right to inspect and copy any medical information from our office.
3. Patients have the right to receive confidential communications.
4. You have the right to amend your protected information.
5. You have the right to an accounting of disclosed personal information.

Schreiber Family Chiropractic reserves the right to change this privacy policy and will provide you with a revised notice at that time.

I have read the above privacy notice and give permission for my personal information to be disclosed as listed in the above notice. I may receive a copy of this notice for my review at any time at my request.

Signature_____ Date_____

Informed Consent

By any standard, chiropractic treatment is a conservative and very safe procedure with little risk. However, we are required to notify you of the very remote possibility of complications. The doctor will use his hands to move your spinal joints. The movement you will feel is normal and expected. Various other procedures like ultrasound & interferential may be used. The purpose of treatment is to promote normal spinal function by increasing spinal joint mobility, flexibility and alignment and to reduce nerve and soft tissue irritation. Delay of treatment may promote formation of adhesions, scar tissue and other degenerative changes such as arthritis. The treatment is also designed to help reduce pain, stiffness and other discomfort. Possible risks of complications from chiropractic treatment are rate and may include fractures, soft tissue strain or a brief period of increased stiffness or discomfort. A serious but very rare complication is a vertebral artery injury. In a report published in the Journal of the CCA, Vol. 37, No. 2, June 1993, the likelihood of this occurrence is one per three million upper neck adjustments. To further reduce your risks, we employ tests in our examination, which are designed to identify you as susceptible to that kind of injury. In contrast, many common medical treatments carry substantial risks. For example, the mortality rates for anesthesia are 20,000 times more dangerous than chiropractic adjustments. The rates of complication for lower intestinal surgery are more than 1,000,000 times greater. Approximately 300,000 deaths occur each year from unnecessary surgery and prescription drug interactions. Prolonged use of ibuprofen is known to cause kidney and liver disease. Excessive use of aspirin can cause bleeding ulcers and also can contribute to a form of stroke.

I have read and understand the above explanation on chiropractic treatment. I know that I have an opportunity to have any questions answered prior to my signing this form. I have fully evaluated the risks and benefits of undergoing this treatment. I have freely decided to undergo and authorize the recommended treatment to my minor dependent, or myself, and hereby give my full consent to treatment.

Patient's Name (please Print) _____

Authorized Signature _____ Date _____

Patient Health Questionnaire – PHQ

Patient Name_____ Date _____

Describe your symptoms: _____

_____

_____

When did your symptoms start? _____

How did your symptoms begin? _____

How often do you experience your symptoms?

1. Constantly (76-100%)
2. Frequently (51-75%)
3. Occasionally (26-50%)
4. Intermittently (0-25%)

What describes your symptoms?

1. Sharp
2. Dull ache
3. Numb
4. Shooting
5. Tightness
6. Throbbing
7. Burning
8. Tingling

How are your symptoms changing?

1. Getting Better
2. Not Changing
3. Getting Worse

Have you experienced these symptoms before?

If yes, when and explain: _____

_____

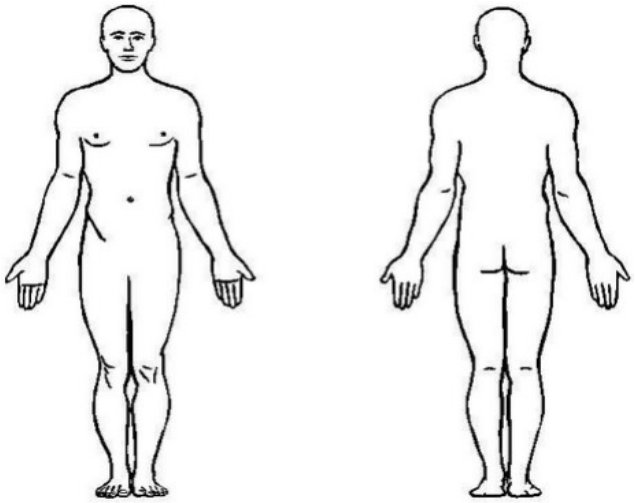
_____

Have you seen anyone for your symptoms?

If yes, explain: _____

_____

Indicate where you have pain or other symptoms:



Indicate the average intensity of your symptoms:

None 1 2 3 4 5 6 7 8 9 10 Unbearable

Please list any current medications and/or supplements: If you are unsure of the name, please list the purpose.

Medication	Dose	Purpose	Prescribed by

On average, how much physical activity, **exercise,** or sports do you participate in during the past month?
None Less than 1x/week 1x/week 2-3x/week 4 or more times/week

Do you use **tobacco** products (ex. cigarettes, chewing tobacco, pipe)?
Yes, currently Yes, in the past (Year quit_____) No, never Not applicable

How many **children** do you have? _____ Female only, please list: # of pregnancies _____ # of births _____

Please list any **allergies**: _____

Please list any **surgeries**: _____
_____

Please list any **traumas or injuries**: _____

Immediate **Family History** of serious health conditions: _____
_____

Personal Health History: Please list any health problems you currently have or have had in the past.

1. Cancer (malignant or metastatic):_____

2. Diabetes (Type I or II): _____

3. Infectious Disease (ex. Hepatitis, HIV):_____

4. Heart, lungs, and circulation (ex. asthma, high blood pressure, previous heart attack, stroke):
_____

5. Digestive System (ex. poor appetite, heartburn, constipation, diarrhea):
_____

6. Psychosocial health (ex. depression, anxiety, violence toward self or others): _____

7. Genitourinary System (difficult or painful urination, kidney stones, sexually transmitted dieases): _____

8. Skeleton and joints (ex. arthritis, stenosis, scoliosis, back or neck pain): _____

9. Nervous System (ex. headaches, dizziness, multiple sclerosis, Parkinson's disease): _____

10. Eyes, ears, nose and throat (ex. loss of vision or hearing, ringing in ears, severe dental problems): _____

11. Skin (ex. rashes, moles, sores):_____

12. Chronic Immune System deficiencies (ex. colds, sinusitis, bronchitis, pneumonia): _____

13. Men's Health problems (ex. enlarged prostate, erectile dysfuncion):_____

14. Women's Health problems (ex. dysmenorrheal, pelvic inflammatory disease, uterine fibroids, ovarian cysts):
_____

15. Other: _____

Patient signature_____

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