Magnolia Tribe Chiropractic

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective. Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

ADJUSTMENT: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

HEALTH: A state of optimal physical, mental and social well-being, not merely the absence of infirmity.

VERTEBRAL SUBLUXATION: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

Today's Date: _____

Name: _____ Date of Birth: ___/____/_____ Age: _____ M ___ F ___

Mailing Address: _____ City: _____ State: ____ Zip Code: _____

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

Ht: _____ Wt: _____ SS#: _____ Marital Status: S ___ M ___ W ___ D ___ # of Children _____

Occupation: _____ Employer: _____ Work Phone: _____

Emergency Contact _____Phone #_____

Relationship to emergency Contact_____

Who may we thank for referring you? _____

Present Family Doctor: _____ Location: _____

Previous Chiropractic Care? Yes ___ No ___ if so, when _____ Chiropractor: _____

Have you had spinal X-Rays within the past 5 years? Yes ___ No ___

If so, when and where _____

Present State of Health

Health Concerns: List according to severity	Rate of Severity 1= mild 10=unbearable	When did this episode start?	Have you had this condition before?	Are symptoms constant or intermittent?
1._____	_____	._____	._____	._____
2._____	_____	._____	._____	._____
3._____	_____	._____	._____	._____
4._____	_____	._____	._____	._____
5._____	_____	._____	._____	._____

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Chiropractic Provides Three Types of Care.

Initial Intensive Care: This includes relief care and initial Vertebral Subluxation Complete care. The goal is to eliminate or reduce your major complaint as well as stabilize your Vertebral Subluxation Complex. This requires frequent visits (several times per week) that may continue for weeks to months. Your Health Insurance may cover this portion of care, since this is dealing with a symptomatic problem**.**

Rehabilitative Care: This rehabilitative care designed to provide optimum healing of the function of the spine, associate tissues and organ systems. This helps prevent the original problem from returning. Frequency of visits varies but it is less than Initial Intensive Care.

Wellness/Maintenance Care: This is designed to maintain your improved health and spinal function. The decision to begin this care is made once it is determined your spine has recovered as best it can from the possible permanent damage that may have occurred prior to care. Visit frequency is based on the needs of the individual and is less than Reconstructive Care.

About Your Health

The human body is designed to be healthy. Throughout life, events occur which damage your health expression. This case history will uncover the layers of damage, especially to your nervous system, that have resulted in poor health. Following your exam, your chiropractor will outline a course of care to begin to correct these layers of damage and recover your innate health potential.

Loss of Whole Body Health

Yes	No	(Birth - Present)	Patient Comment
_____	_____	Did /do you smoke?	_____
_____	_____	Did/do you drink any alcohol?	_____
_____	_____	Diet (Do you eat healthy foods?)	_____
_____	_____	Have you been in any accidents?	_____
_____	_____	Have you had surgery or organs removed/replaced?	_____
_____	_____	Drugs? (Prescription or non-prescription)	_____
_____	_____	Teeth/Jaw problems?	_____
_____	_____	Eye problems?	_____
_____	_____	Hearing problems?	_____
_____	_____	Exercise regularly?	_____
_____	_____	Did/do you have occupational stress?	_____
_____	_____	Physical stress?	_____
_____	_____	Mental stress?	_____
_____	_____	Hobby/Sports injuries?	_____
_____	_____	Sleeping habits (nightmares/sleeplessness?)	_____
_____	_____	Sleeping posture: __ Side __Stomach __Back	_____

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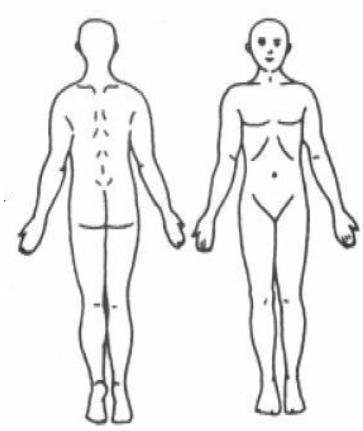
Health History

Is there a family history of:	Heart Disease	Arthritis	Cancer	Diabetes
Father's side	_____	_____	_____	_____
Mother's side	_____	_____	_____	_____

***CIRCLE* any Current Problems you have below:**

DIZZINESS THROAT ISSUES KIDNEY PROBLEMS LIVER DISEASE NERVOUSNESS
HEADACHES THYROID PROBLEMS MID BACK PAIN SHOULDER PAIN EPILEPSY
VERTIGO ASTHMA IRRITABLE BOWEL CHRONIC FATIGUE DISC PROBLEM
ULCERS SCIATICA LUPUS INFERTILITY EAR INFECTIONS
NAUSEA NUMBNESS IN ARMS NUMBNESS IN LEGS FIBROMYALGIA GASTRIC REFLUX
TMJ NUMBNESS IN HANDS NUMBNESS IN FEET CHEST PAIN MIGRANES
NECK PAIN MENSTRUAL DISORDER LOW BACK PAIN ARM PAIN LEG PAIN
ANXIETY CHRONIC SINUSITIS HEART DISEASE KNEE PAIN SLEEPING ISSUES
HIP PAIN BLADDER PROBLEMS STOMACH DISORDERS MEMORY PROBLEMS

Current Concerns Below



PLEASE MARK the areas on the Diagram with the following letters to describe your symptoms: **R**=Radiating **B**=Burning **A**=Aching **N**=Numbness **D**=Dull **S**=Sharp **T**=Tingling

What makes you feel better? _____

What makes you feel worse? _____

Have you suffered with any of this or a similar problem in the past? ☐Yes ☐ No

If yes, how many times? _____ When was the last episode?_____

Please identify any and all types of excess physical, chemical, or emotional stress on you or your body:

_____

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:

___ Broken Bone ___Dislocations ___ Tumors ___Rheumatoid Arthritis ___ Fracture
___Disability ___Heart Attack ___ Cancer ___ Diabetes ___ Stroke
___ Scoliosis ___Osteo Arthritis Other serious conditions: _____

List Prescription & Non-Prescription drugs you take: _____

_____

List any other surgeries, not listed above, you have had: _____

_____

I would like to experience the following benefits from Chiropractic Care:

Check all that apply:

- ◊ ☐ Symptomatic relief of pain or discomfort
- ◊ ☐ Correction of the cause of the problem as well as relief of symptoms
- ◊ ☐ Prevention of future problems
- ◊ ☐ Healthier spine and nerve system
- ◊ ☐ Optimal health on all levels
- ◊ ☐ OTHER_____

What would a personal health goal be for you and the significance of the goal?

Ex) *Reduce headaches so I can play with my grandbabies.*

_____

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
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

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INFORMED CONSENT

We encourage and support a **shared decision making** process between us regarding your health needs. As a part of that process you have a right to be informed about the condition of your health and the recommended care and treatment to be provided to you so that you can make the decision whether or not to undergo such care with full knowledge of the known risks. This information is intended to make you better informed in order that you can knowledgably give or withhold your consent.

Chiropractic is based on the science which concerns itself with the relationship between structures (primarily the spine) and function (primarily of the nervous system) and how this relationship can affect the restoration and preservation of health.

Adjustments are made by chiropractors in order to correct or reduce spinal and extremity joint subluxations. **Vertebral subluxation** is a disturbance to the nervous system and is a condition where one or more vertebra in the spine is misaligned and/or does not move properly, causing interference and/or irritation to the nervous system. The primary goal in chiropractic care is the removal and/or reduction of nerve interference caused by vertebral subluxation.

A **chiropractic examination** will be performed which may include spinal and physical examination, orthopedic and neurological testing, palpation, specialized instrumentation, radiological examination (x-rays), and laboratory testing.

The chiropractic adjustment is the application of a precise movement and/or force into the spine in order to reduce or correct vertebral subluxation(s). There are a number of different methods or techniques by which the chiropractic adjustment is delivered. Some adjustments are delivered by hand, while some may require the use of an instrument or other specialized equipment. Among other things, chiropractic care may reduce pain, increase mobility, and improve quality of life.
In addition to the benefits of chiropractic care and treatment, one should also be aware of the existence of some risks and limitations of this care. The risks are seldom high enough to contraindicate care and all health care procedures have some risk associated with them.

Risks associated with some chiropractic treatment may include soreness, musculoskeletal sprain/strain, and fracture. In addition, there are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke; rather, recent studies indicate that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there is a stroke already in process. However, you are being informed of this reported association because a stroke may cause serious neurological impairment.

I have been informed of the nature and purpose of chiropractic care, the possible consequences of care and the risks of care, including the risk that the care may not accomplish the desired objective. Reasonable alternative treatments have been explained, including the risks, consequences, and probable effectiveness of each. I have been advised of the possible consequences if no care is received. I acknowledge that no guarantees have been made to me concerning the results of care and the treatment.

I HAVE READ THE ABOVE PARAGRAPHS. I UNDERSTAND THE INFORMATION PROVIDED. ALL QUESTIONS I HAVE ABOUT THIS INFORMATION HAVE BEEN ANSWERED TO MY SATISFACTION. HAVING THIS KNOWLEDGE, I KNOWINGLY AUTHORIZE

TO BEGIN CHIROPRACTIC CARE AND TREATMENT

Patient's Signature _____ Date _____

Magnolia Tribe Chiropractic

X-RAY AUTHORIZATION

As your healthcare provider, we are legally responsible for your chiropractic records. We must maintain a record of your x-rays in our files. At your request, we will provide you with a copy of your x-rays in our files.

THE FEE FOR COPYING YOUR X-RAYS ON A DISC IS $15.00. THIS FEE MUST BE PAID IN ADVANCE.

Digital x-rays on a CD will be available within 72 hours of prepayment on any regular practice hours day. Please note: X-rays are utilized in this office to help locate and analyze VERTEBRAL SUBLUXATIONS. However, if any abnormalities are found, we will bring it to your attention so that you can seek proper medical advice.

BY SIGNING BELOW YOU ARE AGREEING TO THE ABOVE TERMS AND CONDITIONS:

Patient's Signature _____ Date _____

***For Women Only:**

**Is there any possibility that you are pregnant? _____ Date of last menses: _____

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

By signing, I authorize Magnolia Tribe Chiropractic to use and/or disclose certain protected health information (PHI) about me for treatment, payment or healthcare operations (TPO) as listed in our extended Notice of Privacy Practices.

This authorization permits Magnolia Tribe Chiropractic to use and/or disclose the following individually identifiable health information about me (specifically describe the information to be used or disclosed, such as date(s) of services, type of services, level of detail to be released, origin of information, etc.) for TPO as listed in our extended Notice of Privacy Practices.

The Practice will not receive payment or other remuneration from a third party in exchange for using or disclosing the PHI.

I hereby authorize the office of Magnolia Tribe Chiropractic to request any medical records, x-rays, MRI reports, CT scans, emergency room reports, physician reports, police reports and/or any pertinent information pertaining to my case history when necessary. I authorized release of medically pertinent information to any requesting hospital, physician, insurance company, or attorney pertaining to my case. This form does not expire unless written notice is given to Magnolia Tribe Chiropractic.

I do not have to sign this authorization in order to receive treatment from Magnolia Tribe Chiropractic. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the privacy officer at:

Social Security Number _____ Date of Birth _____

Patient's Signature _____ Date _____

Magnolia Tribe Chiropractic

Please read the following carefully, then sign and date. Thank you.

Terms of Acceptance

In order to provide for the most effective healing environment, most effective application of chiropractic procedures, and the strongest possible doctor-patient relationship, it is our wish to provide each patient with a set of parameters and declarations that will facilitate the goal of optimum health through chiropractic.

To that end, we ask that you acknowledge the following point regarding chiropractic care and the services that are offered through this clinic:

A. Chiropractic is a very specific science, authorized by law to address spinal health concerns and needs. Chiropractic is a separate and distinct science, art, and practice. It is not the practice of medicine.
B. Chiropractic seeks to maximize the inherent healing power of the human body by restoring normal nerve functions through the adjustment of spinal subluxation(s). Subluxations are deviations from normal spinal structures and configurations that interfere with normal nerve processes.
C. The chiropractic adjustment process, as defined in the law of this jurisdiction, involves the application of a specific directional thrust to a region or regions of the spine with the specific intent of re-positioning misaligned spinal segments. This is a safe, effective procedure applied over one million times each day from doctors of chiropractic in the United States alone.
D. A thorough chiropractic examination and evaluation is part of the standard chiropractic procedure. The goal of this process is to identify any spinal health problems and chiropractic needs. If during this process, any condition or question outside the scope of chiropractic is identified, you will receive prompt referral to an appropriate provider or specialist, according to the initial indications of the need.
E. Chiropractic does not seek to replace or compete with your medical, dental, or other types of health professionals. They retain responsibility for care and management of medical conditions. We do not offer advice regarding treatment prescribed by others.
F. You compliance with care plans, home and self care, etc. is essential to maximal healing and optimal health through chiropractic.
G. We invite you to speak frankly to the doctor on any matter related to your care at this facility, its nature, duration, or cost, in what we work to maintain as a supporting, open environment.

By my signature below, I have read and fully understand the above statements.

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my satisfaction. I therefore accept chiropractic care on this basis.

Patient's Signature _____ **Date** _____

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Practice Policies

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

Questions:
Do not hesitate to ask questions, we want you to be informed. Just as in a good marriage, proper communications is an absolute necessity. Our primary concern is to help you attain your optimum health.

Acknowledgment:
I have read and fully understand the above statements and terms of payment. All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.

Patient's Signature _____ Date _____

Guardian or Spouse's
Signature Authorizing Care _____Date _____