DiPippa Chiropractic Health Records Intake Form

Patient Information

Name _____ Phone _____

Address _____

City _____ State _____ Zip _____

Employer: _____

Date of Birth _____ Gender: ☐ Male ☐ Female • ☐ Single ☐ Married ☐ Widowed

How did you learn about this clinic? _____

Insurance and Release

INSURANCE COVERAGE: _____

I assign directly to DiPippa Chiropractic Center, Inc. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. DiPippa Chiropractic Center, Inc. may use my health care information and may disclose such information to the above named insurance company and their agents, for the purpose of obtaining payment for services and determining insurance benefits payable for related services.

I authorize DiPippa Chiropractic Center, Inc. to discuss my personal Health and/or Financial Information with the following family members:

Name: _____ Name: _____

Release, Privacy Practices Acknowledgement, Informed Consent and Signature on File

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. These 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 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.

I understand it is my responsibility to inform this office of any changes in my medical status. I have received the Notice of Privacy Practices and I have been provided an opportunity to review it. I authorize DiPippa Chiropractic Center, Inc. to contact me or leave a message for me at my home or office.

_____ Date _____

Signature of Patient, Parent, Guardian, or Personal Representative

Patient Condition

Reason for Visit _____

How long have you had this condition? _____

Is this condition due to an accident? ☐ Auto ☐ Work ☐ None DATE:_____

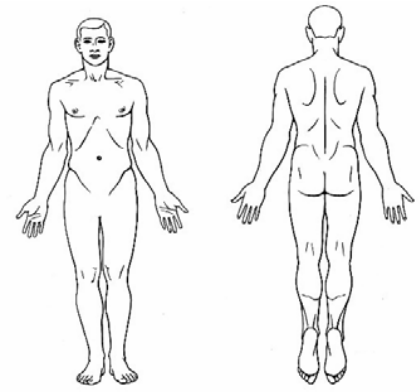
Are you seeing any other physician for this condition? ☐ Yes ☐ No

How often are your symptoms present? ☐ 0 – 25% ☐ 26 – 50% ☐ 51 – 75% ☐ 76 – 100%

Rate the severity of your pain over the past week - 0 (no pain) to 10 (severe pain) _____

Exercise? ☐ None ☐ Moderate ☐ Daily ☐ Heavy

Work Activity? ☐ Sitting ☐ Standing ☐ Light Labor ☐ Heavy Labor



Mark an X on the picture where you have pain or other symptoms

Coffee / Caffeine Drinks? _____ Cups per day **Alcohol?** _____ Drinks per week

High Stress Level? ☐ Yes ☐ No **Reason:**_____

Do You Have a Pacemaker? ☐ Yes ☐ No **Could You Be Pregnant?** ☐ Yes ☐ No ☐ N/A

Mark "yes" or "no" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes	☐ No	Dizziness	☐ Yes	☐ No	Herniated Disc	☐ Yes	☐ No	Prosthesis	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No	Surgeries	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Fractures	☐ Yes	☐ No	High Cholesterol	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Artificial Joints	☐ Yes	☐ No	Gout	☐ Yes	☐ No	Multiple Sclerosis	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Headaches	☐ Yes	☐ No	Osteoporosis	☐ Yes	☐ No	Tumors	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Heart Disorders	☐ Yes	☐ No	Pregnancy	☐ Yes	☐ No	Visual Disturbances	☐ Yes	☐ No
Digestive disorders	☐ Yes	☐ No	Hernia	☐ Yes	☐ No	Prostate Problems	☐ Yes	☐ No	Weight Gain/Loss	☐ Yes	☐ No
Comments											

Health History

Injuries / Surgeries **None** ☐

Surgery _____ Year _____

Surgery _____ Year _____

Surgery _____ Year _____

Back Injuries _____ Year _____

Broken Bones _____ Year _____

Medications _____

Medications _____

Medications _____