

Patient Health History

First Name _____ Middle Name _____ Last Name _____

Date of Birth

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Gender (check one) Male Female Unspecified

Marital Status: Single Married Widowed

Address _____ City _____ State _____ Zip Code _____

Primary Phone _____ Mobile Phone _____

Email _____ I authorize my doctor to contact me via the email address provided.

Employment Status (check one)

Employed FT Student PT Student Other Retired Self Employed

Name of Insurance Policy Holder: _____ Policy Holder DOB: _____

Emergency Contact Name and Phone Number: _____

Have you ever received Chiropractic Care? Yes No If yes, when? _____

Associated health problem of relatives: _____

Job Description _____

Recreational Activities (including gym) _____

Chief Complaint: _____

Location of Complaint: _____

What was the initial cause of this complaint? _____

When did this complaint begin? _____

Are you presently under a doctor's care for this complaint? Y/N Doctors name: _____

Have you had an X-ray or CT scan or MRI of your spine in the past 28 days? Yes No

Please circle the Quality of the complaint pain: dull/aching/sharp/shooting/burning/throbbing/deep/nagging

Does this complaint/pain radiate or travel (shoot) to other areas of your body? Y/N Where? _____

Do you have any numbness or tingling in your body? Where? _____

Grade Intensity/Severity (0 No complaint/pain) 0 1 2 3 4 5 6 7 8 9 10 (10 Worst possible pain/complaint)

How frequent is complaint present. How long does it last? _____

Does anything aggravate the complaint? _____

Does anything make the complaint better? _____

Does this complaint interfere with: work home life activities sleep none of the above? _____

On a scale of 1 – 10. How committed are you to resolving this complaint? _____

Are there any other health concerns you would like to address? _____

Do you currently or have you use tobacco of any kind? Yes Former (In the past) Never

Current medications or vitamins, including frequency and dosage if known. If there are no current medications, check here:

1) _____	Start Date	5) _____	Start Date
2) _____		6) _____	
3) _____		7) _____	
4) _____		8) _____	

Do you have any medication allergies? Yes No Have you taken Antibiotics recently? Yes No

If yes, please list medications? _____

Briefly list past illness, injury or surgery: _____

Has any doctor diagnosed you with Hypertension presently? Yes No If yes, describe: _____

Has any doctor diagnosed you with Diabetes presently? Yes No If yes, what kind? Type I Type II
 If yes to Diabetes, was your blood lab-work test for hemoglobin A1c > 9.0%? Yes No Not Sure

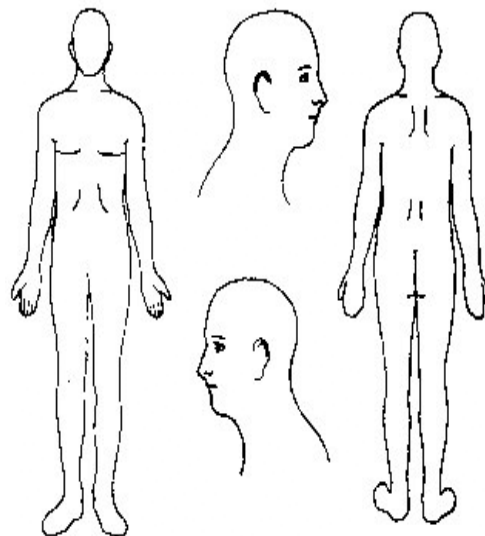
Have you or anyone related to you been diagnosed with any of the following conditions: Marfan's Disease
 Ehler Danlos Syndrome type IV or VI Polycystic Kidney Disease Osteogenesis Imperfecta Type 1
 Fibromuscular Hyperplasia

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office to provide me/child with chiropractic care, in accordance with this state's statutes.

Patient/Guardian's Signature _____ Date _____
 Doctors Signature _____ Date _____

Place an "X" on the drawing over the areas causing you pain and a letter describing it:

- X = PAIN**
- A = ACHE**
- B = BURNING**
- S = STABBING**
- N = NUMBNESS**
- P = PINS & NEEDLES**



HIPAA Consent Form

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment
- Obtain payment from third-party payers
- Conduct normal healthcare operations

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosure of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at 1941 Hoffman Road, STE 6, Gastonia, NC 28054 to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

- Yes, I would like a copy of your Notice of Privacy Practices
- No, I would not like a copy of your Notice of Privacy Practices

Patient/Guardian's Signature: _____ Date: _____

Printed Name: _____

If signed by other than patient, indicate relationship and reason why patient is unable to sign.

Consent To Treatment

Health care providers are required to advise patients of the nature of the treatment to be provided, the risks and benefits of the treatment, and any alternatives to the treatment.

There are some risks that may be associated with treatment, in particular you should note:

- A. 'While rare, some patients have experienced rib fractures or muscle and ligament sprains or strains following treatment;
- B. There have been rare reported cases of disc injuries following cervical and lumbar spinal adjustment although no scientific study has ever demonstrated such injuries are caused, or may be caused, by spinal or soft tissue manipulation or treatment.
- C. There have been reported cases of injury to a vertebral artery following osseous spinal manipulation. Vertebral artery injuries have been known to cause a stroke, sometimes with serious neurological impairment, and may, on rare occasion, result in paralysis or death. The possibility of such injuries resulting from cervical spine manipulation is extremely remote;

Osseous and soft tissue manipulation has been the subject of government reports and multi-disciplinary studies conducted over many years and have demonstrated it to be highly effective treatment of spinal conditions including general pain and loss of mobility, headaches and other related symptoms. Musculoskeletal care contributes to your overall well-being. ***The risk of injuries or complications from treatment is substantially lower than that associated with many medical or other treatments, medications, and procedures given for the same symptoms.***

I acknowledge I have discussed (in person) the following with my healthcare provider:

- a. The condition that the treatment is to address;
- b. The nature of the treatment;
- c. The risks and benefits of that treatment; and
- d. Any alternatives to that treatment.

I have had the opportunity to ask questions and receive answers regarding the treatment.

I consent to the treatments offered or recommended to me by my healthcare provider, including osseous and soft tissue manipulation. I intend this consent to apply to all my present and future care with

Aaron J. Stump, D.C., CCSP® (health care providers name).

Dated this _____ day of _____ 20__

X _____ Patient signature (or Legal Guardian)

Dr. Signature: _____