VIDAN FAMILY CHIROPRACTIC

Name: _____Preferred Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Cell # ( ) _____Work # ( ) _____ Home # ( ) _____

Birthdate: _____ Age: _____ Male _____ Female _____ Pregnant or nursing? ☐Yes ☐ No

Email address: _____

Occupation: _____Employer Name: _____

☐ Single ☐ Married ☐ Divorced ☐ Partnered ☐ Widowed

Spouse/Partner's Name _____# of children_____

Have you seen a Chiropractor before? ☐ Yes ☐ No If yes, when was your last visit? _____

How did you hear about us? ☐ Google ☐ Insurance ☐ Fox 2 ☐ Friend/Family _____

☐ Presentation _____ ☐ Doctor _____ ☐ Other _____

CMS (Centers for Medicare and Medicaid Services) requires providers to report both race and ethnicity

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

Preferred Language: _____

Ethnicity (MUST Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

Are you currently taking any medications? (Please include regularly used over the counter medications)

Medication Name	Dosage (i.e. 5mg)

Do you have any medication allergies?

Medication Name	Reaction	Onset Date

I have received a copy of the Notice of Patient Privacy Policy. _____(Patient Initials)

Doctor's Initials_____

Please check all conditions you have currently or have had in the past, even if they do not seem related to your current problem.

☐ AIDS/HIV	☐ Allergies	☐ Anemia	☐ Anorexia/Bulimia
☐ Appendicitis	☐ Arthritis	☐ Asthma	☐ Autoimmune Problems
☐ Bleeding Disorder	☐ Bowel Disease (IBS, Crohn's, etc)	☐ Bronchitis	☐ Cancer: _____
☐ Depression	☐ Diabetes	☐ Emphysema	☐ Epilepsy
☐ Fractures	☐ Heart Disease	☐ Hernia	☐ Herniated Disc
☐ High Cholesterol	☐ Kidney Disease	☐ High Blood Pressure	☐ Low Blood Pressure
☐ Migraine Headache	☐ Miscarriage	☐ Multiple Sclerosis	☐ Osteoporosis
☐ Pacemaker	☐ Liver Disease/Hepatitis	☐ Pneumonia	☐ Prostate Problems
☐ Rheumatoid Arthritis	☐ Scoliosis	☐ Stroke	☐ Thyroid Problems
☐ Tuberculosis	☐ Ulcers	☐ Urinary Tract Infections	☐ Whiplash
☐ STD	☐ Psychiatric Problems	☐ Alcoholism/Chemical Dependency	

Please check all conditions all conditions for which you have an IMMEDIATE (parent, sibling, child) family history, even if they do not seem related to your current problem. Please list the family member.

☐ AIDS/HIV	☐ Allergies	☐ Anemia	☐ Anorexia/Bulimia
☐ Appendicitis	☐ Arthritis	☐ Asthma	☐ Autoimmune Problems
☐ Bleeding Disorder	☐ Bowel Disease (IBS, Crohn's, etc)	☐ Bronchitis	☐ Cancer: _____
☐ Depression	☐ Diabetes	☐ Emphysema	☐ Epilepsy
☐ Fractures	☐ Heart Disease	☐ Hernia	☐ Herniated Disc
☐ High Cholesterol	☐ Kidney Disease	☐ High Blood Pressure	☐ Low Blood Pressure
☐ Migraine Headache	☐ Miscarriage	☐ Multiple Sclerosis	☐ Osteoporosis
☐ Pacemaker	☐ Liver Disease/Hepatitis	☐ Pneumonia	☐ Prostate Problems
☐ Rheumatoid Arthritis	☐ Scoliosis	☐ Stroke	☐ Thyroid Problems
☐ Tuberculosis	☐ Ulcers	☐ Urinary Tract Infections	☐ Whiplash
☐ STD	☐ Psychiatric Problems	☐ Alcoholism/Chemical Dependency	

List any non-medication allergies you currently have: _____

List any surgeries you have had and the date: _____

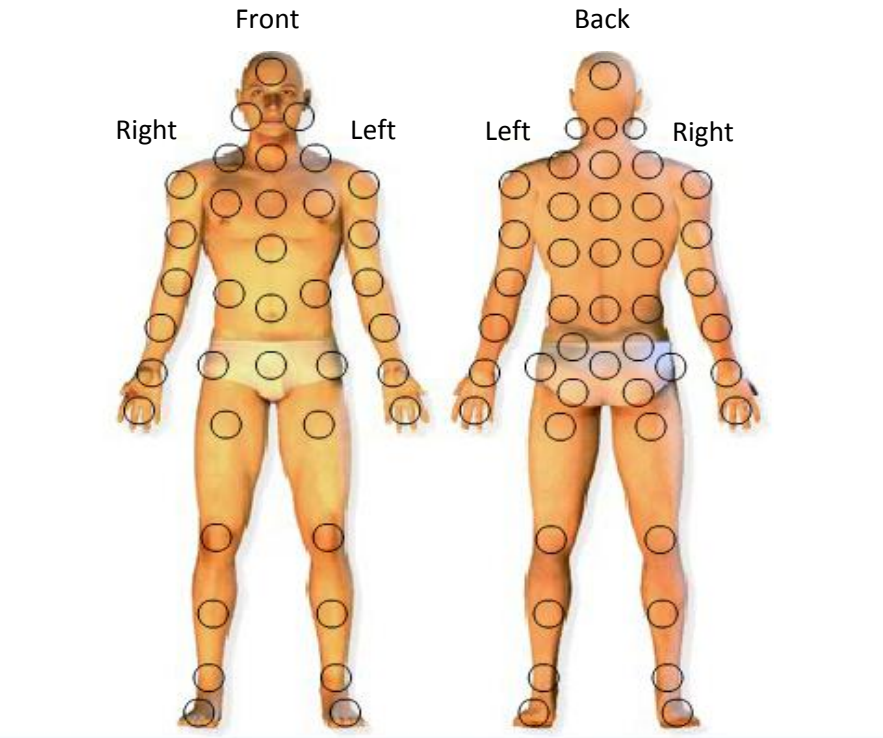
Choose one of the following—A clinical summary includes your demographics and diagnosis codes and does not change from visit to visit.

☐ I *want* to receive my clinical summary after every visit. ***(If yes, please provide an email address on page 1)***

☐ I *do not want* to receive my clinical summary after every visit.

Doctor's Initials_____

Mark an X on your areas of discomfort.



How would you rate the level of discomfort right now on a scale of 0-10 with 0 being no pain and 10 being the worst possible pain (Circle One)?

No Pain Extreme Pain

0 1 2 3 4 5 6 7 8 9 10

What is the frequency of the discomfort you are feeling? (Circle One)

None of the time All of the time

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

How would you rate the discomfort *at its worst*? (Circle One)

No pain Extreme Pain

0 1 2 3 4 5 6 7 8 9 10

How would you rate the discomfort *at its best*? (Circle One)

No pain Extreme Pain

0 1 2 3 4 5 6 7 8 9 10

Describe the onset of the discomfort? (Circle One)

Gradual Sudden

Doctor's Initials_____

When did the discomfort begin?

_____ hours ago _____ days ago _____ weeks ago _____ months ago _____ years ago

Since the problem began, have the symptoms been getting better, worse, or have they been relatively unchanged? (Circle One)

Better Worse Unchanged

What makes the discomfort worse? (Check all that apply)

☐ Bending ☐ Carrying ☐ Chewing ☐ Cleaning ☐ Cooking ☐ Coughing ☐ Driving
☐ Exercising ☐ Gardening ☐ Lifting ☐ Lying Down ☐ Medications ☐ Pulling ☐ Pushing
☐ Running ☐ Sitting ☐ Sleeping ☐ Sneezing ☐ Standing ☐ Stretching ☐ Turning
☐ Twisting ☐ Typing ☐ Walking ☐ Working ☐ Other _____

What relieves the discomfort? (Check all that apply)

☐ Adjustments ☐ Bending ☐ Eating ☐ Exercising ☐ Ice ☐ Lying Down ☐ Medications
☐ Resting ☐ Running ☐ Sitting ☐ Sleeping ☐ Standing ☐ Stretching ☐ Turning
☐ Twisting ☐ Walking ☐ Working ☐ Other _____

How would you describe the discomfort? (Check all that apply)

☐ Aching ☐ Burning ☐ Deep ☐ Dull ☐ Frequent ☐ Intense ☐ Numb
☐ Random ☐ Sharp ☐ Shooting ☐ Throbbing ☐ Tingling ☐ Tightness
☐ Mild ☐ Moderate ☐ Severe ☐ Other _____

When is the discomfort at its worst? (Check One)

☐ In the morning ☐ In the afternoon ☐ In the evening ☐ Just before bed

Signature _____ Date _____

Parent/Guardian Signature _____ Date _____

Doctor's Initials_____

Acknowledgement for Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of your Protected Health Information
Your Protected Health Information will be used by Vidan Family Chiropractic or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Notice of Privacy Practices
You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office.

Requesting a Restriction on the Use or Disclosure of Your Information

- You may request a restriction on the use or disclosure of your Protected Health Information.
- This office may or may not agree to restrict the use or disclosure of your Protected Health Information.
- If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Notice of Treatment in Open or Common Areas
Treatment is given in semi-private areas. Private rooms are available upon request.

Revocation of Consent
You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

Authorized Contact
Authorized contacts are people with whom we may discuss appointments, medical care, account/billing information, etc. Please list your authorized contacts below. These authorized contacts remain in effect until revoked in writing.

Contact name	Phone number	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____

Office Policies

1. **Cell Phone Policy** – Please help us to keep a peaceful, relaxing environment by refraining from cell phone use in our office. If you must take a call, please step either outside the building or into the hallway. Please use headphones or silence your device while watching videos or playing games. _____ **(Initials)**

2. **Image Consent** – Pictures and video are periodically taken during patient hours. In the event you are in the ***background*** of one of these images, you give consent to Vidan Family Chiropractic to use that video or picture without further authorization. In the event that you are the featured subject, further consent will be requested._____ **(Initials)**

3. **Insurance –** Verification of your insurance benefits is not a guarantee of payment. You will be responsible for any unpaid balance. If we submit your insurance claims, the amount due will be based upon our best estimate according to the information provided us by your insurance company. If claims process differently than expected, we will update your amount due according to the information provided on your insurance company's Explanation of Benefits. All co-payments are due at the time of service. You will be refunded any overpayments. _____ **(Initials)**

By my signature below I give my permission to use and disclose my health information and agree to office policies.

Patient Name (please print): _____

Signature: _____ Date: ____/____/____

Doctor's Initials_____

VIDAN FAMILY CHIROPRACTIC

Phone: 314-678-9355 • Fax: 314-721-9559

2230 S. Brentwood Blvd. Brentwood, MO 63144

Informed Consent

Patient Name: _____

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The nature of the chiropractic adjustment.

The primary treatment I use as Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis/Examination/Treatment

As a part of the analysis, examination, and treatment, you are consenting to the following procedures:
(Initial the statement below OR initial each procedure to which you are consenting)

__*I consent to all of the procedures listed below*

If not consenting to all procedures, initial each procedure below to indicate consent:

__*spinal manipulative therapy*	__*palpation*	__*vital signs*
__*range of motion testing*	__*orthopedic testing*	__*basic neurological testing*
__*muscle strength testing*	__*postural analysis*	__*electrical muscle stimulation*
__*hot cold therapy*	__*x-rays*	__*Other (please explain)*

_____

_____

The material risks inherent in chiropractic adjustment.

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications including but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

The probability of those risks occurring.

Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking of your history and during examination and X-ray. Stroke

Doctor's Initials_____

has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

The availability and nature of other treatment options.

Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers
- Hospitalization
- Surgery

If you choose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers of remaining untreated.

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE. PLEASE CHECK THE APPROPRAITE BLOCK AND SIGN BELOW.

I have read [ ] or have had read to me [ ] the above explanation of the chiropractic adjustment and related treatment. I understand that prior to any procedure I have the right to discuss with the doctor and have my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Dated: _____

_____
Patient's Name

_____
Signature

_____
Signature of Parent or Guardian (if a minor)

Dated: _____

A. Vidan, DC
A. Grabowski, DC

_____
Doctor's Name

_____
Signature

Doctor's Initials_____