

ACCOUNT #	ADD <input type="checkbox"/>	Please assist us by <i>clearly</i> and <i>correctly</i> completing the information in the outlined areas. <b>Do not write in the shaded areas.</b> Please give your insurance card(s) to the receptionist for copying.
	ADD <input type="checkbox"/>	
	ADD <input type="checkbox"/>	

**PATIENT INFORMATION**

FIRST	MIDDLE INITIAL	LAST	EMAIL ADDRESS	ACCT. TYPE	GENDER M <input type="checkbox"/> F <input type="checkbox"/>
STREET ADDRESS			MARITAL STATUS <input type="checkbox"/> SIN <input type="checkbox"/> MAR <input type="checkbox"/> SEP <input type="checkbox"/> DIV <input type="checkbox"/> WID	EMPLOYMENT <input type="checkbox"/> FULL <input type="checkbox"/> PART <input type="checkbox"/> RETD <input type="checkbox"/> UNEM	STUDENT? <input type="checkbox"/> FULL <input type="checkbox"/> PART <input type="checkbox"/> NO
CITY	STATE	ZIP	SOCIAL SECURITY # - -	BIRTHDATE - -	SPOUSE'S NAME
HOME PHONE - -	CELL PHONE - -	WORK PHONE - -	EMPLOYER'S NAME	JOB DESCRIPTION	

**BILLING INFORMATION (leave blank if same as above)**

FIRST NAME	MIDDLE INITIAL	LAST NAME	MAIL CODE	ACCT. TYPE
STREET ADDRESS			CITY	STATE ZIP

**PRIMARY COVERAGE**

POLICY HOLDER NAME	RELATIONSHIP TO INSURED SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> DAUGHTER <input type="checkbox"/> SON <input type="checkbox"/> OTHER <input type="checkbox"/> DISABLE <input type="checkbox"/>
PRIMARY INSURANCE CO. NAME & ADDRESS	CERT/CONTRACT # GROUP #
EMPLOYER	SOCIAL SECURITY # BIRTHDAY CARRIER CD #

**SECONDARY COVERAGE**

POLICY HOLDER NAME	RELATIONSHIP TO INSURED SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> DAUGHTER <input type="checkbox"/> SON <input type="checkbox"/> OTHER <input type="checkbox"/> DISABLE <input type="checkbox"/>
PRIMARY INSURANCE CO. NAME & ADDRESS	CERT/CONTRACT # GROUP #
EMPLOYER	SOCIAL SECURITY # BIRTHDAY CARRIER CD #

**AUTHORIZATION**

THE ABOVE SUBSCRIBER HEREBY AUTHORIZES HIS/HER INSURANCE COMPANY TO ISSUE INDEMNITY CHECKS TO THE ABOVE LISTED MEDICAL PROVIDER FOR SERVICES PROVIDED.

I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for services to the physician or organization furnishing the services and authorize such physician OR organization to submit a claim to my insurance carrier OR Medicare for payment. I authorize any holder of medical or other information about me to release to insurance carriers OR the Health Care Financing Administration and its agents OR the Social Security Administration or its intermediaries OR any agency, group or person(s) necessary to secure payment any information needed for this of related Medicare claim. \*For and in consideration of services rendered and to be rendered by the above listed medical provider, I hereby guarantee payment of all charges incurred for this account. \* The patient or his/her representative recognizing the need for health care, consents to the above listed medical provider rendering services as ordered by the physicians, including medical or surgical treatment, laboratory procedures, x-ray examinations or other services rendered under the general and specific instructions of the physicians. \* I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct.

DATE \_\_\_\_\_ PATIENT SIGNATURE (Parent/Guardian if minor) \_\_\_\_\_

**CONFIDENTIAL PATIENT CASE HISTORY**

REASON FOR APPOINTMENT: WHAT CONDITION'S SYMPTOMS ARE YOU CURRENTLY EXPERIENCING?

ARE THE CAUSES KNOWN TO YOU? IF SO, WHAT ARE THEY?

DO ANY POSITIONS MAKE IT FEEL BETTER?

DO ANY POSITIONS MAKE IT FEEL WORSE?

OVER TIME, THIS CONDITION HAS:  
 IMPROVED     WORSENERD     NOT CHANGED

THIS CONDITION INTERFERES WITH:    WORK   
 SLEEP     DAILY ROUTINE     OTHER

OTHER DOCTORS OR THERAPISTS INVOLVED IN TREATING THIS CONDITION:

LIST SURGICAL PROCEDURES AND YEARS UNDERGONE:

**REVIEW OF SYMPTOMS**

<b>GENERAL</b>	NOW	PAST	<b>EARS</b>	NOW	PAST	<b>MOUTH</b>	NOW	PAST
WEAKNESS	<input type="checkbox"/>	<input type="checkbox"/>	HARD OF HEARING	<input type="checkbox"/>	<input type="checkbox"/>	BLEEDING GUMS	<input type="checkbox"/>	<input type="checkbox"/>
FATIGUE	<input type="checkbox"/>	<input type="checkbox"/>	DEAFNESS	<input type="checkbox"/>	<input type="checkbox"/>	SORES	<input type="checkbox"/>	<input type="checkbox"/>
FEVER	<input type="checkbox"/>	<input type="checkbox"/>	RINGING	<input type="checkbox"/>	<input type="checkbox"/>	DENTAL PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>
CHILLS	<input type="checkbox"/>	<input type="checkbox"/>	DISCHARGE	<input type="checkbox"/>	<input type="checkbox"/>	BAD BREATH	<input type="checkbox"/>	<input type="checkbox"/>
NIGHT SWEATS	<input type="checkbox"/>	<input type="checkbox"/>	EARACHE	<input type="checkbox"/>	<input type="checkbox"/>	LOSS OF TASTE	<input type="checkbox"/>	<input type="checkbox"/>
FAINTING	<input type="checkbox"/>	<input type="checkbox"/>	ITCHING	<input type="checkbox"/>	<input type="checkbox"/>	DRY MOUTH	<input type="checkbox"/>	<input type="checkbox"/>
			DIZZINESS	<input type="checkbox"/>	<input type="checkbox"/>	ULCERS	<input type="checkbox"/>	<input type="checkbox"/>
			ROOM SPINS	<input type="checkbox"/>	<input type="checkbox"/>	BLISTERS	<input type="checkbox"/>	<input type="checkbox"/>
<b>SKIN</b>	NOW	PAST	<b>NOSE</b>	NOW	PAST	<b>THROAT</b>	NOW	PAST
COLOR CHANGES	<input type="checkbox"/>	<input type="checkbox"/>	DECREASE SMELL	<input type="checkbox"/>	<input type="checkbox"/>	SORENESS	<input type="checkbox"/>	<input type="checkbox"/>
NAIL CHANGES	<input type="checkbox"/>	<input type="checkbox"/>	BLEEDING	<input type="checkbox"/>	<input type="checkbox"/>	BAD TONSILS	<input type="checkbox"/>	<input type="checkbox"/>
HAIR CHANGES	<input type="checkbox"/>	<input type="checkbox"/>	PAIN	<input type="checkbox"/>	<input type="checkbox"/>	HOARSENESS	<input type="checkbox"/>	<input type="checkbox"/>
MOLES	<input type="checkbox"/>	<input type="checkbox"/>	DISCHARGE	<input type="checkbox"/>	<input type="checkbox"/>	PAIN	<input type="checkbox"/>	<input type="checkbox"/>
RASHES	<input type="checkbox"/>	<input type="checkbox"/>	OBSTRUCTION	<input type="checkbox"/>	<input type="checkbox"/>	TROUBLE SWALLOWING	<input type="checkbox"/>	<input type="checkbox"/>
SORES	<input type="checkbox"/>	<input type="checkbox"/>	POST NASAL DRIP	<input type="checkbox"/>	<input type="checkbox"/>	RECURRENT INFECTIONS	<input type="checkbox"/>	<input type="checkbox"/>
WEAKNESS	<input type="checkbox"/>	<input type="checkbox"/>	DEVIATED SEPTUM	<input type="checkbox"/>	<input type="checkbox"/>			
<b>HEAD</b>	NOW	PAST	RUNNY NOSE	<input type="checkbox"/>	<input type="checkbox"/>	<b>BREASTS</b>	NOW	PAST
HEADACHES	<input type="checkbox"/>	<input type="checkbox"/>	SINUS CONGESTION	<input type="checkbox"/>	<input type="checkbox"/>	DISCHARGE	<input type="checkbox"/>	<input type="checkbox"/>
INJURIES	<input type="checkbox"/>	<input type="checkbox"/>	<b>NECK</b>	NOW	PAST	LUMPS	<input type="checkbox"/>	<input type="checkbox"/>
BUMPS	<input type="checkbox"/>	<input type="checkbox"/>	NECK ENLARGEMENT	<input type="checkbox"/>	<input type="checkbox"/>	PAIN	<input type="checkbox"/>	<input type="checkbox"/>
GLASSES	<input type="checkbox"/>	<input type="checkbox"/>	STIFF NECK	<input type="checkbox"/>	<input type="checkbox"/>	BLEEDING	<input type="checkbox"/>	<input type="checkbox"/>
CONTACTS	<input type="checkbox"/>	<input type="checkbox"/>	SORENESS	<input type="checkbox"/>	<input type="checkbox"/>	NIPPLE CHANGES	<input type="checkbox"/>	<input type="checkbox"/>
CATARACTS	<input type="checkbox"/>	<input type="checkbox"/>	LUMPS	<input type="checkbox"/>	<input type="checkbox"/>	SKIN CHANGES	<input type="checkbox"/>	<input type="checkbox"/>
LAST EYE EXAM DATE _____			MASSES	<input type="checkbox"/>	<input type="checkbox"/>	BLOATED	<input type="checkbox"/>	<input type="checkbox"/>

PATIENT NAME

NUMBER

DATE



**REVIEW OF SYMPTOMS (cont.)**

<b>ENDOCRINE</b>	NOW PAST	<b>PAST MEDICAL HISTORY</b>	<b>DATE OF LAST CHEST X-RAY:</b>	
WEIGHT LOSS	<input type="checkbox"/> <input type="checkbox"/>	HAY FEVER	NORMAL?	
WEIGHT GAIN	<input type="checkbox"/> <input type="checkbox"/>	MUMPS		
EXTREMELY THIN	<input type="checkbox"/> <input type="checkbox"/>	RHEUMATIC FEVER		
HEAT INTOLERANCE	<input type="checkbox"/> <input type="checkbox"/>	ALLERGIES		
COLD INTOLERANCE	<input type="checkbox"/> <input type="checkbox"/>	ANGINA		
HAIR CHANGES	<input type="checkbox"/> <input type="checkbox"/>	CANCER		
BREAST CHANGES	<input type="checkbox"/> <input type="checkbox"/>	TUMOR	<b>LAST TB SKIN TEST:</b>	
<b>MUSCULOSKELETAL</b>		BLOOD DISEASE		NORMAL?
	NOW PAST	LEUKEMIA		
MUSCLE PAIN	<input type="checkbox"/> <input type="checkbox"/>	HEART TROUBLE		
MUSCLE WEAKNESS	<input type="checkbox"/> <input type="checkbox"/>	VARICOSE VEINS		
MUSCLE CRAMPS	<input type="checkbox"/> <input type="checkbox"/>	PHLEBITIS		
MUSCLE TWITCHING	<input type="checkbox"/> <input type="checkbox"/>	HYPERTENSION		
JOINT TWITCHING	<input type="checkbox"/> <input type="checkbox"/>	STROKE	<b>ALLERGIES:</b>	
JOINT PAIN	<input type="checkbox"/> <input type="checkbox"/>	JAUNDICE		
<b>IMMUNIZATION/VACCINATION</b>		SKIN TROUBLE		
DPT	<input type="checkbox"/>	GALLSTONES		
MUMPS	<input type="checkbox"/>	LIVER TROUBLE		
SMALLPOX	<input type="checkbox"/>	HEPATITIS		
TYPHOID	<input type="checkbox"/>	PARASITES	<b>SOCIAL HISTORY</b>	
TETANUS	<input type="checkbox"/>	EPILEPSY		
MEASLES	<input type="checkbox"/>	PARALYSIS		
PNEUMOCOCCAL	<input type="checkbox"/>	POLIO		
INFLUENZA	<input type="checkbox"/>	MENTAL ILLNESS		
POLIO	<input type="checkbox"/>	ALCOHOLISM		
MMR	<input type="checkbox"/>	DEPRESSION	CURRENT WEIGHT: _____	
<b>BLOOD TYPE:</b>		NERVOUS BREAKDOWN	HAVE YOU RECENTLY LOST OR GAINED WEIGHT? _____	
<b>BLOOD TRANSFUSIONS</b>		MIGRAINE	<b>MENTAL WORK:</b>	
DATES:		GOUT	HEAVY <input type="checkbox"/> MEDIUM <input type="checkbox"/> LIGHT <input type="checkbox"/>	
		HEMORRHOIDS	HOURS PER DAY: _____	
		PROSTATE PROBLEMS	<b>PHYSICAL WORK:</b>	
		SEXUAL PROBLEMS	HEAVY <input type="checkbox"/> MEDIUM <input type="checkbox"/> LIGHT <input type="checkbox"/>	
		GONORRHEA	HOURS PER DAY: _____	
		SYPHILIS	<b>EXERCISE:</b>	
		DIABETES	HEAVY <input type="checkbox"/> MEDIUM <input type="checkbox"/> LIGHT <input type="checkbox"/>	
		BLADDER TROUBLE	HOURS PER WEEK: _____	
		KIDNEY STONES	TYPE: _____	
		KIDNEY INFECTIONS	<b>SMOKING:</b>	
		DYSENTERY	CURRENT <input type="checkbox"/> PREVIOUS <input type="checkbox"/>	
			PACKS/DAY: ___ # OF YEARS: _____	
			<b>ALCOHOL:</b>	
			BEER/WK: _____ WINE/WK: _____	
			LIQUOR/WK: ___ # OF YEARS: _____	
			<b>CAFFEINE:</b>	
			COFFEE <input type="checkbox"/> TEA <input type="checkbox"/> COLA <input type="checkbox"/>	
			CUPS/DAY: _____ # OF YEARS: _____	
			<b>ASPIRIN:</b>	
			#/DAY: _____ # OF YEARS: _____	
			<b>OTHER:</b>	

PATIENT NAME

NUMBER

DATE

**FAMILY HISTORY**

	AGE (if living)	AGE AT DEATH	CAUSE OF DEATH	STATE OF HEALTH	ILLNESSES
FATHER	_____	_____	_____	_____	_____
MOTHER	_____	_____	_____	_____	_____
BROTHER(S)	_____	_____	_____	_____	_____
SISTER(S)	_____	_____	_____	_____	_____
MATERNAL GRANDFATHER	_____	_____	_____	_____	_____
MATERNAL GRANDMOTHER	_____	_____	_____	_____	_____
PATERNAL GRANDFATHER	_____	_____	_____	_____	_____
PATERNAL GRANDMOTHER	_____	_____	_____	_____	_____

**CURRENT SYMPTOMS**

**MARK THE AREAS OF YOUR SYMPTOMS ON THE FIGURES TO THE RIGHT. Use the following symbols:**

- ACHES: ^^^^
- NUMBNESS: OOOO
- PINS/NEEDLES: >>>>
- STABBING PAIN: ////

**MARK AN 'X' ON THE LINES:**

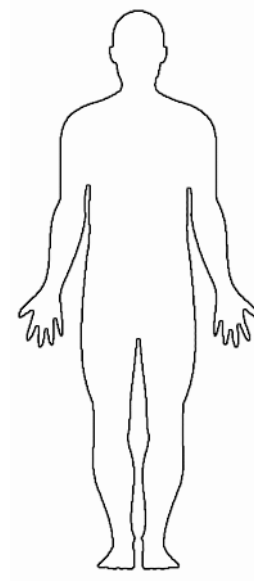
HOW BAD ARE YOUR SYMPTOMS NOW?

-----  
 NONE SEVERE

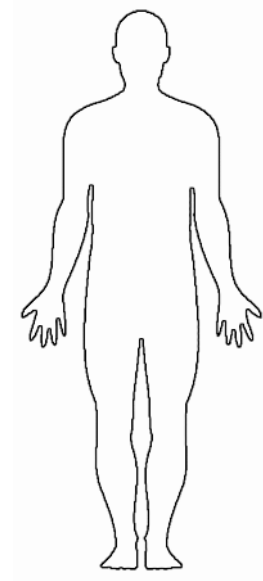
HOW BAD HAVE THEY BEEN IN THE PAST?

-----  
 NONE SEVERE

**FRONT**



**BACK**



PATIENT NAME

NUMBER

DATE

**X-RAY/PREGNANCY INFORMATION**

I give permission to Pinnacle Chiropractic to take plain x-ray films for diagnostic purposes.

I also acknowledge that, if female, I am not pregnant.

This form must be signed by a parent or guardian if the patient is a minor.

Print Patient Name: \_\_\_\_\_

Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare options.

**Patient Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**HEALTH CARE AUTHORIZATION FORM**

Patient's Name: \_\_\_\_\_

Patient's SS #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

THE PATIENT IDENTIFIED ABOVE AUTHORIZES PINNACLE CHIROPRACTIC TO USE AND/OR DISCLOSE PROTECTED HEALTH INFORMATION IN ACCORDANCE WITH THE FOLLOWING:

**Specific Authorizations**

Initial:

\_\_\_\_\_ I give permission to Pinnacle Chiropractic to use my address, phone number and clinical records to contact me with birthday cards, holiday related cards and information about treatment alternatives or other health related information.

(OPEN ROOM AUTHORIZATION – OPTIONAL)

\_\_\_\_\_ I give Pinnacle Chiropractic permission to treat me in an open room where other patients are also being treated. I am aware that other persons in the office may overhear some of my protected health information during the course of care. Should I need to speak with the doctor any time in private, the doctor will provide a room for these conversations.

\_\_\_\_\_ By signing this form, you are giving Pinnacle Chiropractic permission to use and disclose your protected health information in accordance with the directives listed above.

**Expiration**

The authorization shall expire on the following date: \_\_\_\_\_

**Right to Revoke Authorization**

You have the right to revoke this authorization, in writing, at any time. However, your written request to revoke this is not effective to the extent that we have provided services or taken action in reliance on your authorization.

You may revoke this authorization by mailing or hand delivering a written notice to the Privacy Official of Pinnacle Chiropractic. The written notice must contain the following information:

- Name, Social Security and Date of Birth
- A clear statement of your intent to revoke this authorization
- The date of your request
- Your signature

The revocation is not effective until it is received by the Privacy Official.

This authorization is requested by Pinnacle Chiropractic for its own use/disclosure of PHI.  
(Minimum necessary standards apply)

You have the right to refuse to sign this authorization. If you refuse to sign this authorization, pinnacle Chiropractic will not refuse to provide treatment.

A copy of the signed authorization will be provided to you on request.

\_\_\_\_\_  
**Print Name of Patient**

\_\_\_\_\_  
**Signature of Patient**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Signature of Personal Representative**

**Description of Representative's Authority to Act for Patient:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## TREATMENT INFORMATION

The primary treatment used by doctors of chiropractic is spinal manipulation or adjustments. We will use this procedure in your treatment program.

### The Nature of Chiropractic Manipulation

We will use our hands to manipulate or loosen and reposition the joints of your spine. Often with this procedure, you will hear a popping noise associated with the loosening of repositioning.

### The Material Risks Inherent to Chiropractic Manipulation

As with any health care procedure, there are certain complications that may arise from chiropractic manipulation. These complications may include aggravation of degenerative or injured spinal discs, rib fractures, ligament sprains, muscle strains, nerve injury or spinal cord compression. Manipulation of the neck has been associated with injury to arteries in the neck leading to or contributing to stroke. Local soreness and or stiffness is typical in the early phases of treatment.

### Probability of Those Risks Occurring

Fractures are rare occurrences and generally result from underlying bone weaknesses, which we check for during the history, examination and x-rays. The exact incident of stroke is uncertain, but it is generally believed to occur in less than one in one-million treatments. We employ physical tests that are advocated to screen for this risk, but they are generally accepted as being insensitive. All other complications are also generally described as rare.

### The Availability and Nature of Other Treatment Options

Other treatment options for your condition may include:

- Over-the-counter medications and rest
- Medical care which may include anti-inflammatory drugs, muscle relaxants and pain medications.
- Surgery

### Material Risks Inherent to Your Other Treatment Options

The common analgesics and anti-inflammatory drugs have been shown to cause damage to the stomach and intestines and possible to the kidneys. Approximately one in 150 patients taking anti-inflammatory drugs for extended time periods requires hospitalization for stomach ulceration. There are about 16,500 deaths in the U.S. each year from these complications, which is more common than deaths from either Hodgkin's disease or cervical cancer. The risks are similar for both prescription anti-inflammatory as well as over-the-counter medications.

Spine surgery may be a consideration for some cases. However, it is reserved for those cases where extensive conservative treatment has been tried. Spine surgery is associated with a minor complication rate of between nine per 100 and 15 per 100 cases depending on the area of the spine involved. More serious complications of the nervous system may occur in one per 400 cases, and death has been reported in approximately one per 1,500. While spinal manipulation is associated with complications in a small number of cases, it has a complication rate of several thousand times less than other typical treatment options.

### DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE

I have read \_\_\_\_\_ or have had read to me \_\_\_\_\_ the above explanation of chiropractic manipulation or adjustment and related treatment. I have discussed it with the doctor and have had my questions answered to my satisfaction. By signing below, I state that I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interests to undergo the treatment recommended. Having been informed of the risks, I hereby give consent to that treatment. Dated: \_\_\_\_\_

\_\_\_\_\_  
Printed Name - Patient

\_\_\_\_\_  
Printed Name - Witness

\_\_\_\_\_  
Signature - Patient

\_\_\_\_\_  
Signature - Witness

\_\_\_\_\_  
Signature of Guardian (if a minor)