New Practice Member Initial Interview

Welcome to Restore Chiropractic Center. Your time here today is as important for you as it is for us. The information you fill in here is paramount to the Chiropractor reaching conclusions and directional decisions about your health, from the past to the present and into the future. If there is anything you're not sure of then please don't hesitate to ask one of our friendly team members.

Last Name: _____ First: _____ Preferred Name: _____

Gender: Male Female Date of Birth: _____ Age: _____

Circle one of the following: Single Partner Married Divorce Widowed

Mailing Address: _____Zip Code_____

Occupation_____Employer_____

Email: _____

Spouse's Name: _____

Phone: H: _____ Work: _____Can we contact you at work?_____

Cell: _____ SS#: _____

Please indicate the best number to contact you (Circle): Home Work Cell
Other: _____

Current Health Story:

What concerns do you feel *Restore Chiropractic* can address for you? (Please be specific):

_____

_____

When did this start? _____

What do you think you did to yourself? _____

_____

Have you experienced this before, if so please elaborate: _____

_____

How would you describe the intensity/sensation? Sharp Dull Burning Numbness Other:_____
Does this radiate to any part(s) of your body? _____
How often do you experience it? Constant Intermittent Occasionally Rarely
Does it vary during the day and if so how?_____
What activities/actions aggravate it? _____
What activities/actions lessen it? _____
Has it changed since you first noticed it and if so how? _____
Are you taking/applying any home remedies/medications for this? **Yes** **No**
If yes, what, how much and how often? _____
_____

How does it interfere with your life?			Work:	Yes	No	Recreation/Play:	Yes	No
Walking:	Yes	No	Sleep:	Yes	No	Social Life:	Yes	No
Sitting:	Yes	No	Eating:	Yes	No	Exercise:	Yes	No

What do you hope we can do for you? _____
_____
How long do you think that will take? _____
Why did you make the decision to come now? _____
_____

Family Story:

Do you have children? **Yes** **No** Do you plan to have children? **Yes** **No**
Names of Children and Ages:
_____
_____

For Women:
Are you pregnant? Yes No Date of Last Menstrual Period:_____
If x-rays are recommended, your signature is required (below) to indicate that you are **not pregnant**:
Signature:_____ Today's Date:_____
If pregnant, approximate due date:_____ Name of OBGYN/Midwife:_____
Where will you be birthing your baby? Hospital Birth Center Home Other_____

Chiropractic Story:

Have you received chiropractic care in the past? **Yes** **No** Did you have x-rays? **Yes** **No**
If yes to care, from whom and how long? _____
How regular was the care? (Circle) Weekly Bi-monthly Monthly Other: _____
Reason(s) for stopping? _____

Discovery Story:

How did you discover us? _____

Family Story:

Please list any significant health history of any family member and their relation to you (i.e. mother, father, sibling, grandparent): _____
_____
_____

History of Physical Stresses (Birth to Present):

Birth Stress: Research indicates that the birth process can cause trauma to a baby's spine and nervous system. Please indicate to the best of your recollection how YOU were birthed:

[ ] Drug Induced [ ] Cesarean Section [ ] Breech [ ] Natural [ ] Forceps
[ ] Prolonged [ ] Cord around neck [ ] At home [ ] In hospital [ ] Suction

General Physical Trauma: Most traumas occur in the early years (between birth and age 18-21). It is during those years that your spine and nerve system is growing and most impressionable. The information below will help us to see the types of stresses that you have been subjected to.

Have you had any accidents related to the following: (check all that apply and give dates):
[ ] Automobile (even as a passenger) [ ] Motorcycle [ ] Bicycle [ ] Sports [ ] Other: _____
If yes, explain how and when:_____
Have you ever injured your spine (neck, head, back, hips)? Yes No
If yes, explain how and when:_____
Have you ever broken any bones or sprained any part of your body? Yes No
If yes, explain how and when:_____
Have you ever been hospitalized? Yes No
If yes, explain how and when:_____

History of Chemical Stresses :

Chemical stresses occur during life due to any substance that is breathed, injected, taken by mouth, or placed in the skin that is toxic to the body. (food allergies, drug reactions, exposure to chemicals in the air, etc.) The following will give us insight into any exposures you may have had.

Have you been vaccinated? Yes No
Do you or have you ever taken?
[ ] Prescription Drugs [ ] Over the counter drugs [ ] Recreational drugs
Have you been exposed to? [ ] Chemicals [ ] Fumes [ ] Dust [ ] Smoke
Do you consume? [ ] Alcohol [ ] Coffee/Caffeine [ ] Tobacco
List current medications:_____
Any medications previously taken for more than 6 months?_____

History of Emotional Stresses:

It is difficult to separate the emotional stress in our life from the physical response that often occurs. Please indicate if you have experienced any of the emotional stresses below.

[ ] Childhood trauma [ ] Loss of loved one [ ] Relationships [ ] Family
[ ] Work or School [ ] Divorce/separation [ ] Financial [ ] Abuse
[ ] Lifestyle change [ ] Parents' divorce [ ] Illness [ ] Other

I CERTIFY THE INFORMATION ON THIS FORM IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

New Practice Member Name (please print):_____ Date: _____/_____/_____

New Practice Member Signature: _____

Name and Signature of parent or legal guardian: _____ (If <18 years of age):

System Story:

Our physical and functional (systems and organs) health are related and rarely do concerns occur separate to other changes. This is because of the nerve system's extensive network and communication pathways. An organ under stress will have a corresponding area of the spine under stress. ***Therefore, please check all symptoms you have ever had, even if they do not seem related to your current problem.***

UNBALANCED NERVOUS SYSTEM

UNDER-AROUSED

- ☐ Poor Attention
- ☐ Impulsive
- ☐ Easily Distracted
- ☐ Disorganized
- ☐ Depressed
- ☐ Lacking Motivation
- ☐ Poor Concentration
- ☐ Constipation
- ☐ Low Pain Threshold
- ☐ Difficulty Waking
- ☐ Worry
- ☐ Irritable
- ☐ Kidney
- ☐ Difficulty Urinating
- ☐ Low Energy

UNSTABLE

- ☐ Migraines
- ☐ Headaches
- ☐ Seizure
- ☐ Sleepwalking
- ☐ Hot Flashes
- ☐ PMS/Menstrual Issues
- ☐ Food Sensitivities
- ☐ Bed Wetting
- ☐ Eating Disorders
- ☐ Bipolar Disorders
- ☐ Mood Swings
- ☐ Panic Attacks
- ☐ Gall Bladder
- ☐ Thyroid
- ☐ Liver
- ☐ Musculoskeletal (back pain, neck pain, sciatica)

OVER-AROUSED

- ☐ Cold Hands/Feet
- ☐ Asthma
- ☐ Respiratory Circulation
- ☐ Tight Muscles
- ☐ Teeth Grinding
- ☐ Anxiety
- ☐ Heart Palpitations
- ☐ Restless Sleep
- ☐ Poor Expression of Emotions
- ☐ Poor Immune System
- ☐ Racing Mind
- ☐ High Blood Pressure
- ☐ Accelerated Aging
- ☐ Irritable Bowel
- ☐ Allergies/Sinusitis
- ☐ Skin

EXHAUSTED NERVOUS SYSTEM

☐ Cancer ☐ Rheumatoid Arthritis ☐ Diabetes ☐ Multiple Sclerosis ☐ ALS

☐ Depression ☐ Chronic Fatigue Syndrome ☐ Fibromyalgia ☐ Epstein-Barr Syndrome

Restore
Chiropractic Center

8318 Lakeview Street | Ralston, NE 68127 | 402.933.1933 | www.aksarbenchiropractic.com

Notice of Privacy Policy

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health research, and law enforcement activities.

Any other disclosures for the purposes of treatment, payment or practice operations will be made only after obtaining your consent.

- You may request restrictions on your disclosures.
- You may inspect and receive copies of your records within 30 days with a request
- You may request to view changes to your records
- In the future, we may contact you for appointment reminders, announcements and to inform you about our practice and its staff.

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 and follow up with multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician's certifications.

The following office procedures allow Restore Chiropractic to operate in an efficient manner and allow us to support our practice members with their care. By signing below you are giving us authorization to follow through with these procedures. Should you desire something not to be done, place a line through anything you refuse and initial.

- We many need to contact you by telephone or text at home or at work regarding appointments and other matters related to care/appointments in this office.
- We may need to leave a message with another person (spouse, co-worker) or on an answering machine/voice mail at home or at work regarding appointments and other matters related to care in this office.
- We routinely have mailings (including postcards) from our office sent to you at home or email address.
- We acknowledge and think everyone who refers friends or family members to our office for chiropractic care. We would like to directly thank the person who referred you and use your name.
- When you refer anyone to us, we would like to directly thank you and publically thank you on the office bulletin board. We also have "Patient of the Week" and "Family of the Month", if selected we would like to recognize you by posting a sign on the office bulletin board, on our Facebook page and social media websites, and on our website.
- We often take and post photos of our practice members in the office, in our newsletters, on Facebook and social media sites, and on our website.

You have the right to refuse any of this authorization without affecting your care or the relationship with anyone at Restore Chiropractic. This authorization may be revoked by you at any time. Revocation may be accomplished by advising us in writing of your desire to withdraw your authorization. Please allow a reasonable processing time for the change in our system to be completed.

I have read and understand your Notice of Privacy Practices. A more complete description can be requested. I also understand that I can request, in writing, that you restrict how my personal information is used and or disclosed.

PATIENT NAME (PLEASE PRINT):_____

PATIENT SIGNATURE:_____ **DATE:** _____

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Medical Information (HIPAA) Release Form

Name: _____ **Date of Birth:** ____ / ____ / ____

Release of Information

[ ] I authorize the release of information including the diagnosis; records; examination rendered to me; and claims, billing, and account information. This information may be released to:

- [ ] Spouse _____
- [ ] Child(ren) _____
- [ ] Attorney _____
- [ ] Other _____

[ ] Information is not to be released to anyone.

This **Release of Information** will remain in effect until terminated by me in writing.

Signed: _____ Date: _____/ _____/ _____

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Informed Consent Form

Chiropractic care is recognized as being an effective and safe method of care for many areas of life.

However, as in all health care, there are some very slight risks with chiropractic care.
This includes, but is not limited to:

- Your condition becoming worse;
- Disc injuries, rib fracture, sprains/strains (1 in 139,000 in the neck and 1 in 62,000 in the low back) [1];
- Stroke or stroke like symptoms (1 in 5.85 million neck adjustments) [2] [3].

*Put in context, chiropractic has been shown to be **250 times safer** than anti-inflammatory drugs [4] and safer than driving a car [5].*

Some people may experience some mild soreness for 24 – 48 hours after their adjustments, especially when their body is unwinding [6] [7]. This is a normal sign of change, as may occur after exercise or stretching.

Clinical experience consistently demonstrates *unexpected improvement* in people's life. One study indicated that 23% of people experience improvement in some other aspect of their health.[8] Of individuals who experience such improvements:

- 26% experienced improvements in their respiratory system;
- 25% in their digestive system;
- 14% circulatory system/heart;
- 14%: eyes/vision.

Broken down into subcategories the benefits were reported as follows:

- Easier to breathe: 21%,
- Improved digestive function: 20%,
- Clearer/better/sharper vision: 11%,
- Better circulation: 7%
- Changes in heart rhythm/blood pressure: 5%,
- Less ringing in the ears/improved hearing: 4%

(The reference for the information quoted above are available upon request.)

Agreement:

I have read and understood the information above. I do not expect the chiropractor to be able to anticipate or explain all the risks and complications. I wish to rely on the chiropractor to exercise his/her judgment during the course of care which he/she feels at the time, based upon the facts known, is in my best interests. I have, to the best of my knowledge, provided the chiropractor with a complete and accurate health history. I have had the opportunity to discuss with the chiropractor the nature and purpose of chiropractic adjustments and other procedures as well as other concerns. I understand that results are not guaranteed. I intend this consent form to cover the entire course of my chiropractic care for this and any future presentation at Restore Chiropractic. I hereby request and consent to chiropractic adjustments and other chiropractic suggestions wherever the chiropractor determines necessary. By signing below I agree to chiropractic care.

Print name: _____ **Signature:** _____
(Parent /guardian if under 18 years)

Chiropractor's signature: _____ **Date:** _____

(1) Dvorak study in Principles and Practice of Chiropractic, Haldeman, 2nd Ed.
(2) Arterial Dissections Following Cervical Manipulation: The Chiropractic Experience. Haldeman S et al. Canadian Medical Association Journal, Vol 165, No 7, 905-906, 2001.
(3) The Mechanics of Neck Manipulation with Special Consideration of the Vertebral Artery. Herzog W, Symons B. J Can Chiropr Assoc 46(3):134-136, 2002.
(4) A Risk Assessment of Cervical Manipulation vs. NSAID's for the Treatment of Neck Pain. Dabbs V, Lauretti W. J Manipulative Physiol Ther 1995; 18(8);530-6
(5) What are the Risks of Chiropractic Neck Adjustments. Lauretti W. JACA 1999; 36(9);42-47.
(6) Leboeuf-Yde C, Axen I, Ahlefeldt G, Lidefelt P, Rosenbaum A, Thurnherr T. The types of improved nonmusculoskeletal Side effects of chiropractic treatment: a prospective study. Leboeuf-Yde C. J Manipulative Physiol Ther. 1997 Oct;20(8):511-5
(7) Frequency and characteristics of side effects of spinal manipulative therapy. Senstad O et al. Spine. 1997 Feb 15;22(4):435-40; discussion 440-1.
(8) Symptoms reported after chiropractic spinal manipulative therapy. *J Manipulative Physiol Ther* 1999;22:559-64.