BEACHSIDE
CHIROPRACTIC
& WELLNESS

Name_____ Today's Date_____/_____/_____

DOB _____/_____/_____ Age_____Height _____ Weight _____

Address _____City_____ State_____ Zip Code_____

Phone _____-_____-_____ Email Address _____

Marital Status: S____M____ W____ D____ # of Children _____ Occupation _____

Emergency Contact:

Name_____ Phone _____-_____-_____ Relationship _____

Present Family Doctor Name _____ Phone _____-_____-_____

Who may we thank for referring you? _____

Previous Chiropractic Care? *Y* *N* If so, when?_____ Chiropractor _____

Have you had spinal X-rays in the last 5 years? *Y* *N* If so, where?_____ when?_____

Past Medical History

Have you ever been treated for any of the following illnesses? Check all that apply.

____Arthritis	____Hepatitis	____Rheumatoid
____Bronchitis	____Heart Attack	____Scoliosis
____Cancer	____Heart Disease	____Stroke
____Diabetes	____High Blood Pressure	____Thyroid Disorder
____Dislocations	____Immunodeficiency	____Ulcers
____Fractures	____Lupus	Other _____

Previous Surgeries? Yes _____ No _____ If so, when and what type? _____

_____

Prescriptions and Supplements

Please list all current prescriptions/supplements_____

_____

Allergies

Please list all known allergies _____

Family History

Please check any that apply

____Arthritis ____Cancer ____Diabetes ____Heart Disease ____High Blood Pressure ____Lupus

____Rheumatoid ____Scoliosis ____Stroke ____Thyroid Disorder Other _____

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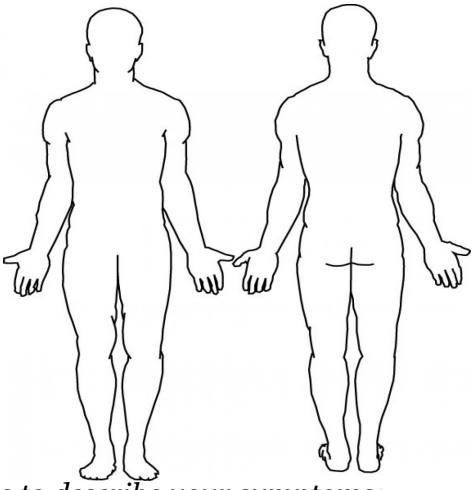
Please describe your current health concerns (why are you here?):

_____

_____



Was this related to a Motor Vehicle Accident? *Y* *N*

Was this a work related injury? *Y* *N*

When did your symptoms begin? _____

What makes you feel better? _____

What makes you feel worse? _____

Have you suffered with this or a similar problem in the past? *Y* *N*

If yes, how many times? _____ When was the last episode?_____

PLEASE MARK the areas on the Diagram with the following letters to describe your symptoms:

A=Aching B=Burning D=Dull N=Numbness R=Radiating S=Sharp T=Tingling

Please identify any and all types of excess physical, chemical, or emotional stress on you or your body:

_____

Review of Systems

Please check any that apply

____Fever
____Weight loss
____Double vision
____Fatigue

____Appetite loss
____Weight change
____Diarrhea
____Constipation
____Abdominal Pain
____Reflux

____Arthritis
____Fractures
____Sprain
____Joint Pain
____Joint Swelling

____Double vision
____Blurring vision

____Ear Infections
____Short of Breath
____Asthma
____Cough

____Deafness
____Sinusitis
____Hoarseness
____Vertigo

____Chest Pain
____Palpitations

____Easy Bruising
____Blood Clots
____Bleeding Disorders

____Anxiety
____Depression
____Sleep Disturbances

____Hair Loss
____Weight Gain
____Excess Thirst
____Decrease Energy

____Speech Impairment
____Trouble Swallowing
____Stroke
____Seizures
____Headaches
____Numbness

____Urinary hesitancy
____Urinary incontinence
____Burning urination
____Menstrual problems
____Infertility

____Rashes
____Lesion

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INFORMED CONSENT

We encourage and support a **shared decision making** process between us regarding your health needs. As a part of that process you have a right to be informed about the condition of your health and the recommended care and treatment to be provided to you so that you can make the decision whether or not to undergo such care with full knowledge of the known risks. This information is intended to make you better informed in order that you can knowledgeable give or withhold your consent.

Chiropractic is based on the science which concerns itself with the relationship between structures (primarily the spine) and function (primarily of the nervous system) and how this relationship can affect the restoration and preservation of health.

Adjustments are made by chiropractors in order to correct or reduce spinal and extremity joint subluxations. **Vertebral subluxation** is a disturbance to the nervous system and is a condition where one or more vertebrae in the spine is misaligned and/or does not move properly, causing interference and/or irritation to the nervous system. The primary goal in chiropractic care is the removal and/or reduction of nerve interference caused by vertebral subluxation.

A **chiropractic examination** will be performed which may include spinal and physical examination, orthopedic and neurological testing, palpation, specialized instrumentation, radiological examination (x-rays), and laboratory testing.

The chiropractic adjustment is the application of a precise movement and/or force into the spine in order to reduce or correct vertebral subluxation(s). There are a number of different methods or techniques by which the chiropractic adjustment is delivered. Some adjustments are delivered by hand, while some may require the use of an instrument or other specialized equipment. Among other things, chiropractic care may reduce pain, increase mobility, and improve quality of life.

In addition to the benefits of chiropractic care and treatment, one should also be aware of the existence of some risks and limitations of this care. The risks are seldom high enough to contraindicate care and all health care procedures have some risk associated with them.

Risks associated with some chiropractic treatment may include soreness, musculoskeletal sprain/strain, and fracture. In addition, there are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke; rather, recent studies indicate that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there is a stroke already in process. However, you are being informed of this reported association because a stroke may cause serious neurological impairment.

I have been informed of the nature and purpose of chiropractic care, the possible consequences of care and the risks of care, including the risk that the care may not accomplish the desired objective. Reasonable alternative treatments have been explained, including the risks, consequences, and probable effectiveness of each. I have been advised of the possible consequences if no care is received. I acknowledge that no guarantees have been made to me concerning the results of care and the treatment.I HAVE READ THE ABOVE PARAGRAPHS. I UNDERSTAND THE INFORMATION PROVIDED. ALL QUESTIONS I HAVE ABOUT THIS INFORMATION HAVE BEEN ANSWERED TO MY SATISFACTION. HAVING THIS KNOWLEDGE, I KNOWINGLY AUTHORIZE TO BEGIN CHIROPRACTIC CARE AND TREATMENT.

Patient's Signature _____ **Date** _____/_____/_____

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X-RAY AUTHORIZATION

It is not unusual for our office to take digital x-rays in the process of determining how we can best help you. X-rays are utilized in this office to help locate and analyze VERTEBRAL SUBLUXATIONS. However, if any abnormalities are found, we will bring it to your attention so that you can seek proper medical advice.

As your healthcare provider, we are legally responsible for your chiropractic records. We must maintain a record of your x-rays in our files. At your request, we will provide you with a copy of your x-rays in our files.

THE FEE FOR COPYING YOUR X-RAYS ON A DISC IS $15.00. THIS FEE MUST BE PAID IN ADVANCE.

Digital x-rays on a CD will be available within 72 hours of prepayment on any regular practice hours day..

BY SIGNING BELOW YOU ARE AGREEING TO THE ABOVE TERMS AND CONDITIONS:

Patient's Signature _____ **Date** _____/_____/_____

For Women Only:

**Is there any possibility that you are pregnant? _____ Date of last menses: _____/_____/_____

PHOTO/VIDEO CONSENT

We are PROUD of our patients and the progress they make while under our care!

There's nothing we enjoy more than CELEBRATING our patients' successes along with them. And when something good is happening in our lives, we feel inclined to share it with others, right?

If the moment arises, we would love to share your photo/video, story, or progress on our Social Media page(s) or website in the interest of showing others that "real people" visit our office and are smiling while they're here – and most importantly, getting results!

Please check the box that applies to you:

_____Sure! You can use my picture on the Beachside Chiropractic & Wellness Website and Social Media (i.e. Facebook, Instagram, etc.) pages, as long as I look good in it!

_____ No thanks! I'll pass for now.

Patient's Signature _____ **Date** _____/_____/_____

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PRIVACY PRACTICES

This notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and other outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of chiropractic students, licensing, and conducting or arranging for other business activities. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

This authorization permits Beachside Chiropractic & Wellness to use and/or disclose the following individually identifiable health information about me (specifically describe the information to be used or disclosed, such as date(s) of services, type of services, level of detail to be released, origin of information, etc.).The Practice will not receive payment or other remuneration from a third party in exchange for using or disclosing the PHI.

I hereby authorize the office of Beachside Chiropractic & Wellness to request any medical records, x-rays, MRI reports, CT scans, emergency room reports, physician reports, police reports and/or any pertinent information pertaining to my case history, when necessary.I authorized release of medically pertinent information to any requesting hospital, physician, insurance company, or attorney pertaining to my case.

This form does not expire unless written notice is given to Beachside Chiropractic & Wellness. When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule.

I do not have to sign this authorization in order to receive treatment from Beachside Chiropractic & Wellness. In fact, I have the right to refuse to sign this authorization.

By signing, I authorize Beachside Chiropractic & Wellness to use and/or disclose certain protected health information (PHI) about me for treatment, payment or healthcare operations.

Patient's Signature _____ **Date** _____/_____/_____

Social Security Number _____ **Date of Birth** _____/_____/_____

TERMS OF ACCEPTANCE

In order for Beachside Chiropractic & Wellness to provide the most effective healing environment, it is essential for both the patient and provider to be working towards the same objective. We ask that you acknowledge the following points regarding chiropractic care and other services that are offered in our office:

A. Chiropractic is a very specific science, authorized by law to address spinal health concerns and needs. Chiropractic is a separate and distinct science, art, and practice. It is not the practice of medicine.
B. Chiropractic seeks to maximize the inherent healing power of the human body by restoring normal nerve functions through the adjustment of spinal subluxation(s). Subluxations are deviations from normal spinal structures and configurations that interfere with normal nerve processes. As Chiropractors, OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our method is a specific adjustment to correct vertebral subluxations.
C. The chiropractic adjustment process, as defined in the law of this jurisdiction, involves the application of a specific directional thrust to a region or regions of the spine with the specific intent of re-positioning misaligned spinal segments. This is a safe, effective procedure applied over one million times each day from doctors of chiropractic in the United States alone.
D. A thorough chiropractic examination and evaluation is part of the standard chiropractic procedure. The goal of this process is to identify any spinal health problems and chiropractic needs. If during this process, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, you will receive prompt referral to an appropriate provider or specialist, according to the initial indications of the need. We do not offer to diagnose or treat any disease or condition other than vertebral subluxation.
E. Chiropractic does not seek to replace or compete with your medical, dental, or other types of health professionals. They retain responsibility for care and management of medical conditions. We do not offer advice regarding treatment prescribed by others.
F. As Chiropractors, we reserve the right to recommend adjunctive therapies including physiotherapy, acupuncture and/or nutritional advice to maximize the effects of your treatment plan.
G. Your compliance with care plans, home and self care, etc. is essential to maximal healing and optimal health through chiropractic.
H. We invite you to speak openly to the doctor or provider on any matter related to your care at this facility, its nature, duration, or cost, in what we work to maintain as a supporting, open environment.

Consent for Chiropractic Care:

I, _____ have read and fully understand the above statements and I consent to treatment at Beachside Chiropractic & Wellness by its providers. All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.

Patient's Signature_____ Date _____/_____/_____

Consent for Chiropractic Care for a Minor:

I, _____ being the parent or legal guardian of _____ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Guardians's Signature_____ Date _____/_____/_____