

PERSONAL INFORMATION

Patient Name: _____ Home Phone: _____
Address: _____ Work Phone: _____
City / State / Zip: _____ Cell Phone: _____
Birth Date: _____ Age: _____ Height: _____ Weight: _____ E-Mail: _____
Social Security #: _____
Occupation: _____ Employer: _____
Spouse's Name: _____ Employer: _____
Spouse's Occupation: _____ Work Phone: _____
By Whom Were You Referred?: _____
In Emergency Notify: _____ Phone: _____
Who is your Primary Care Physician? _____
May we send him / her a report concerning this appointment? Yes No

CURRENT HEALTH CONDITION

Purpose of this appointment: _____
Other doctors seen for this condition? No Yes Who? _____
Type of treatment: _____ Results: _____
When did this condition begin? _____ Has this condition occurred before? Yes No
Symptoms are better in the: A.M. Mid-Day P.M.
Symptoms are worse in the: A.M. Mid-Day P.M. Symptoms do not change with time of day
Are you currently taking any medication? _____
Do you suffer from any condition other than that of which you are consulting us? _____

PAST HEALTH HISTORY

Please Check and Describe:

Major Surgery / Operation: Back Surgery Hernia Gall Bladder Appendectomy

Other: _____

Broken Bones _____

Major Accident or Fall: _____

Hospitalization: _____

Previous Chiropractic Care? No Yes Approx. Date of Last Treatment? _____

Below is a list of diseases which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of chiropractic care.

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

- | | | |
|--|--|---|
| <input type="checkbox"/> Polio | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Cancer | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Mental Disorders |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Thyroid Disorders | <input type="checkbox"/> Pleurisy |

Have you been tested HIV positive? ___Yes ___No

CHECK ANY OF THE FOLLOWING YOU HAVE HAD IN THE PAST 6 MONTHS:

MUSCULO-SKELETAL

- Low Back Pain
- Pain Between Shoulders
- Neck Pain
- Arm Pain
- Joint Pain / Stiffness
- Walking Problems
- Jaw Pain / TMJ

NERVOUS SYSTEM

- Numbness
- Paralysis
- Dizziness
- Forgetfulness
- Confusion
- Depression
- Fainting
- Cold / Tingling Extremities

GENITO-URINARY

- Bladder Trouble
- Painful Urination
- Excessive Urination
- Discolored Urine

EENT

- Recent Vision Changes
- Recent Dental Changes
- Hearing Difficulty

GASTRO-INTESTINAL

- Poor / Excessive Appetite
- Excessive Thirst
- Nausea
- Vomiting
- Diarrhea
- Constipation
- Liver Problems
- Gall Bladder Problems
- Abdominal Cramps
- Colitis
- Black / Bloody Stool
- Heartburn
- Gas / Bloating

CARDIO-VASCULAR

- Chest Pain
- Shortness of Breath
- Blood Pressure Problems
- Irregular Heartbeat
- Heart Problems
- Lung Problems
- Varicose Veins
- Ankle Swelling
- Stroke

MALE / FEMALE

- Menstrual Irregularity
- Breast Pain / Lumps
- Prostate / Sexual Dysfunction

GENERAL

- Fatigue
- Allergies
- Headaches
- Other: _____

FEMALES ONLY:

Are you pregnant? ___Yes ___No ___Not Sure Date of your last menstrual cycle: _____

PAIN SCALE:

Using the scale of 0 - 10, with 0 = no pain and 10 = worst pain possible, please write the number indicating your present pain level in the box below:

PAIN BODY DIAGRAM:

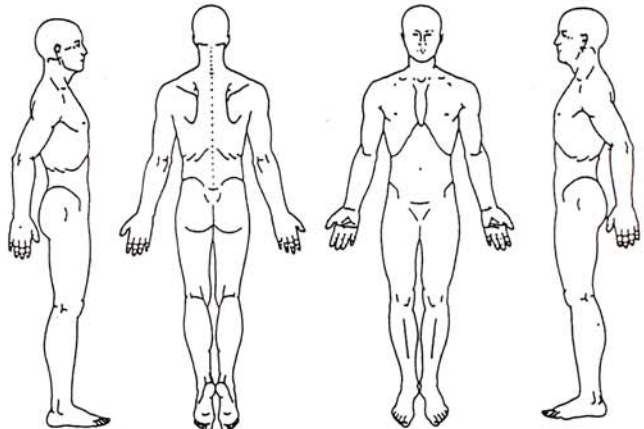
Please use the following indicators to accurately mark the areas of your complaints on the diagram below:

Dull Pain: X X

Numbness: = =

Stabbing Pain: /// ///

Tingling (Pins & Needles): ::: :::



FINANCIAL POLICY

It is our office policy that all services rendered are charged directly to you the patient and that you are ultimately responsible for all payments, regardless of whether or not this office accepts insurance assignment.

1. Deductibles and co-payments are expected at the time of service, or at the end of each week. Patient balances may not exceed \$200.00 at any time, or professional care may be terminated unless other arrangements have been made.
2. This office does not guarantee that an insurance company will pay for the usual and customary charges of this office, nor will this office enter into any dispute with an insurance company over reimbursement. Ultimately the patient is responsible for his / her bill.
3. Should you discontinue care for any reason other than discharge by the doctor, any and all balances will become immediately due and payable in full by you, regardless of any claims submitted.
4. Delinquent accounts will be subject to a 15% annual interest rate. A \$25.00 service charge and a \$10.00 collection fee will be added to any and all accounts placed in collections.

INFORMED CONSENT FOR CHIROPRACTIC ADJUSTMENTS AND TREATMENT

I hereby request and consent to the performance of chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by Kevin R. Marsh, D.C.

I understand the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all of the risks and complications and wish to rely on the doctor to exercise judgment during the course of the procedures which the doctor feels at the time, based upon facts known, is in my best interests.

I have read, or have had read to me, the above financial policy and consent. I have also had the opportunity to ask questions about their content, and by signing below, I agree to the above named procedures / policies. I intend this form to cover the entire course of treatment for my present condition and for future condition(s) for which I seek treatment.

To be completed by patient:

Complete if necessary:

Print patient's name

Name of guardian

Signature of patient

Signature of guardian

Date signed

Relationship

Hayden Lake Chiropractic
8235 Cornerstone Drive
Hayden, Idaho 83835
(208) 762-0222
Patient 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 and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your *Notice of Privacy Practice* containing a more complete description of the uses and disclosures 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 the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above 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 healthcare 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.

Patient Name: _____

Signature: _____

Relationship to Patient: _____

Date: _____