CONNECT CHIROPRACTIC

Dr. Brett Haderlie, D.C.

Patient Information (Please Print)

Thank you for choosing our practice for your chiropractic needs.

Name _____ Date_____ SS/HIC/Patient ID#_____
Address_____ City_____ State_____ Zip_____
Birthdate_____ Sex: Female Male E-mail_____
Home Phone(____)_____ Cell Phone (___)_____ Work Phone(___)_____
Marital Status ☐Married ☐Widowed ☐ Single ☐Minor ☐ Separated ☐ Divorced
Patient Employer/School_____ Occupation_____
Employer/School Address_____ City_____ State _____Zip_____
Spouse or Parent's name _____Employer _____Work Phone(___)_____
Whom may we thank for referring you to us?_____
Person to contact in case of emergency_____ Phone (___)_____

Insurance Information Do you have medical insurance? ☐Yes ☐No

Name of insured_____ Relationship to patient _____
Insured's birthdate_____ Social Security # _____
Insurance Company_____ Policy ID_____
Name of employer_____ Work Phone (___)_____
DO YOU HAVE ADDITIONAL INSURANCE? ☐Yes ☐No
Name of secondary insured_____ Relationship to patient _____
Insured's birthdate_____ Social Security # _____
Name of employer_____ Work Phone (___)_____
Insurance Company_____ Policy ID_____

Responsible Party

Name of person responsible for this account_____
Relationship to patient_____ Phone (___) _____
Address_____ City_____ State _____Zip_____
Name of employer _____Work Phone (___) _____

Certification and Assignment

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

I certify that I, and/or my dependent(s), have the above insurance coverage and assign directly to the treating doctor all insurance benefits, if any, otherwise payable to me for services rendered. If the insurance company reimburses me directly, I will remit payment to the doctor within 30 days. I understand that I am financially responsible for all charges whether or not paid by insurance. I am responsible to know my policy benefits and limits and update the office of such information. I authorize the use of my signature on all insurance submissions. I am aware that I am personally responsible for charges not covered by my insurance. Interest will be charged at 18% on outstanding accounts. Should collection become necessary the responsible parte agrees to pay an additional 40% collection fee and all legal fees. I hereby state and agree that a photocopy of this document will be as valid and binding on all parties involved as the original copy.

The doctor may use my health care information and may disclose such information to the Insurance Company(ies) and agencies for the purpose of obtaining payment for services and determining insurance benefits payable for related services.

_____ _____
Signature of Patient, Parent, Guardian or Personal Respresentative Date

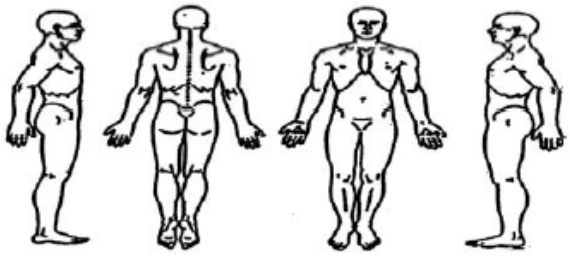
_____ _____
Please print name of Patient, Parent Guardian or Personal Representative Date

PATIENT INTAKE FORM

Patient Name: _____ Date: _____

1. Is today's problem caused by: □ Auto Accident □ Workman's Compensation

2. Indicate on the drawings below where you have pain/symptoms



3. How often do you experience your symptoms?

□ Constantly (76-100% of the time) □ Occasionally (26-50% of the time)
□ Frequently (51-75% of the time) □ Intermittently (1-25% of the time)

4. How would you describe the type of pain?

□ Sharp □ Numb
□ Dull □ Tingly
□ Diffuse □ Sharp with motion
□ Achy □ Shooting with motion
□ Burning □ Stabbing with motion
□ Shooting □ Electric like with motion
□ Stiff □ Other:_____

5. How are your symptoms changing with time?

□ Getting Worse □ Staying the Same □ Getting Better

6. Using a scale from 0-10 (10 being the worst), how would you rate your problem?

0 1 2 3 4 5 6 7 8 9 10 (*Please circle*)

7. How much has the problem interfered with your work?

□ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely

8. How much has the problem interfered with your social activities?

□ Not at all □ A little bit □ Moderately Quite a bit □ Extremely

9. Who else have you seen for your problem?

□ Chiropractor □ Neurologist □ Primary Care Physician
□ ER physician □ Orthopedist □ Other:_____
□ Massage Therapist □ Physical Therapist □ No one

10. How long have you had this problem? _____

11. How do you think your problem began?

_____

12. Do you consider this problem to be severe?

□ Yes □ Yes, at times □ No

13. What aggravates your problem?

_____

14. What concerns you the most about your problem; what does it prevent you from doing?

_____

15. What is your: Height_____ **Weight** _____ **Age** _____
Occupation _____

16. How would you rate your overall Health?

□ Excellent □ Very Good □ Good □ Fair □ Poor

17. What type of exercise do you do?

□ Stenuous □ Moderate □ Light □ None

18. Indicate if you have any immediate family members with any of the following:

□ Rheumatoid Arthritis	□ Diabetes	□ Lupus
□ Heart Problems	□ Cancer	□ ALS

19. For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

Past	Present	Past	Present	Past	Present
□	□ Headaches	□	□ High Blood Pressure	□	□ Diabetes
□	□ Neck Pain	□	□ Heart Attack	□	□ Excessive Thirst
□	□ Upper Back Pain	□	□ Chest Pains	□	□ Frequent Urination
□	□ Mid Back Pain	□	□ Stroke	□	□ Smoking/Tobacco Use
□	□ Low Back Pain	□	□ Angina	□	□ Drug/Alcohol Dependance
□	□ Shoulder Pain	□	□ Kidney Stones	□	□ Allergies
□	□ Elbow/Upper Arm Pain	□	□ Kidney Disorders	□	□ Depression
□	□ Wrist Pain	□	□ Bladder Infection	□	□ Systemic Lupus
□	□ Hand Pain	□	□ Painful Urination	□	□ Epilepsy
□	□ Hip Pain	□	□ Loss of Bladder Control	□	□ Dermatitis/Eczema/Rash
□	□ Upper Leg Pain	□	□ Prostate Problems	□	□ HIV/AIDS
□	□ Knee Pain	□	□ Abnormal Weight Gain/Loss		
□	□ Ankle/Foot Pain	□	□ Loss of Appetite	**For Females Only**	
□	□ Jaw Pain	□	□ Abdominal Pain	□	□ Birth Control Pills
□	□ Joint Pain/Stiffness	□	□ Ulcer	□	□ Hormonal Replacement
□	□ Arthritis	□	□ Hepatitis	□	□ Pregnancy
□	□ Rheumatoid Arthritis	□	□ Liver/Gall Bladder Disorder		
□	□ Cancer	□	□ General Fatigue		
□	□ Tumor	□	□ Muscular Incoordination		
□	□ Asthma	□	□ Visual Disturbances		
□	□ Chronic Sinusitis	□	□ Dizziness		
□	□ Other:_____				

20. List all prescription medications you are currently taking:

_____

21. List all of the over-the-counter medications you are currently taking:

_____

22. List all surgical procedures you have had:

_____

23. What activities do you do at work?

□ **Sit:**	□ Most of the day	□ Half the day	□ A little of the day
□ **Stand:**	□ Most of the day	□ Half the day	□ A little of the day
□ **Computer work:**	□ Most of the day	□ Half the day	□ A little of the day
□ **On the phone:**	□ Most of the day	□ Half of the day	□ A little of the day

24. What activities do you do outside of work?

_____

25. Have you ever been hospitalized? □ No □ Yes

if yes, why _____

26. Have you had significant past trauma? □ No □ Yes

27. Anything else pertinent to your visit today?_____

Patient Signature_____ **Date:**_____

Informed Consent for Chiropractic Care

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks and alternatives.

Chiropractic is a science and art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may effect the restoration and preservation of health. **Health** is a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

One disturbance to the nervous system is called a **vertebral subluxation**. This occurs when one or more of the 24 vertebrae in the spinal column become misaligned and/or do not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by an **adjustment.** An adjustment is the specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine. Adjustments are usually done by hand but may be performed by handheld instruments. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included.

If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

_____ _____ _____

Print Name Signature Date

Consent to evaluate and adjust a minor child:

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

_____ _____

Parent Signature If *patient* Is a minor Date

Pregnancy Release:

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual cycle: _____

_____ _____

Signature Date

CONSENT FOR THE USE OF DISCLOSURE OF HEALTH INFORMATION

Our Privacy Pledge

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will respect the privacy of your health information.

There are several circumstances in which we disclose your health care information.

- We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for diagnosis, assessment or treatment.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your health information within our practice for quality control or other operational purposes.
- We may need to use your personal information to remind you of your appointments, send you a birthday card, send you a thank you for your referrals, acknowledge our referral on an in-office referral board, send you a welcome to our office, invite you to participate in patient appreciation days, send you an office newsletter, or send promotional information.
- We practice in this office an "open adjusting" environment. "Open adjusting" involves several patients having therapy in an open area and also involves this patient being adjusted in an open adjusting room (no doors). Patients are within sight of one another and some ongoing routine details of care are discussed within earshot of other patients and staff. It is our view that the kinds of matters related in an "open adjusting" environment are incidental matters. In the event that you or someone else would not agree with us, a closed room may be furnished.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before you sign this consent form. We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come for treatment or by mail. Please feel free to call us at any time for a copy of our privacy notices .We will not provide your health information to any individual, company or organization without your signed authorization except as mentioned above. You are entitled to inspect and/or copy your health information at any time upon request for seven years or for as long as the information remains in our files.

Our Right to Revoke Your Authorization

You may revoke your consent to us at any time; however, your revocation must be in writing. We will not honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give you authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

I have read you consent policy and agree to its terms. I am also acknowledging that I have received a copy of this notice.

_____ _____

Print Name Print Authorized Provider Representative

_____ _____ _____ _____

Date Signature Date Signature