PATIENT APPLICATION FOR TREATMENT

TODAY'S DATE: _____ ACCT # _____

NAME: _____ HOW WOULD YOU LIKE TO BE ADDRESSED? _____

DATE OF BIRTH: _____ AGE: _____ GENDER: _____

YOUR ADDRESS: _____ CITY: _____

STATE: _____ ZIP: _____ HOME PHONE: _____ WORK PHONE: _____

YOUR OCCUPATION: _____ MOBILE PHONE: _____

EMPLOYER: _____

SUPERVISORS'S NAME: _____

ADDRESS/LOCATION: _____ CITY: _____ STATE: _____ ZIP: _____

MARITIAL STATUS **S M W D** OCCUPATION: _____

EMPLOYER: _____ WORK PHONE: _____

HOW MANY CHILDREN DO YO HAVE? _____ WHAT ARE THEIR AGES? _____

HAVE THEY OR ANY OTHER MEMBERS OF YOUR FAMILY RECEIVED CHIROPRACTIC CARE? ❑ Yes ❑ No

HAVE YOU EVER HAD CHIROPRACTIC CARE? ❑ Yes ❑ No HOW LONG HAS IT BEEN? _____

THE PURPOSE OR REASON FOR THIS APPOINTMENT? _____

HOW OFTEN DO YOU DRINK ALCOHOLIC BEVERAGES? _____

DO YOU SMOKE? ❑ Yes ❑ No HOW MUCH? _____

DO YOU EXERCISE ❑ Yes ❑ No HOW OFTEN? _____ TYPE? _____

HAVE YOU EVER SUFFERED FROM OR BEEN DIAGNOSED AS HAVING: (CIRCLE YES OR NO FOR EACH)

Y	N	*Broken or Fractured Bones	Y	N	*Osteoarthritis	Y	N	Eating Disorder
Y	N	Circulatory Problems	Y	N	Epilepsy	Y	N	Alcoholism
Y	N	*Rheumatoid Arthritis	Y	N	Pacemaker	Y	N	Drug Addiction
Y	N	Seizures/Convulsions	Y	N	Strokes	Y	N	HIV Positive
Y	N	A Congenital Disease	Y	N	*Cancer	Y	N	Gall Bladder
Y	N	Excessive Bleeding	Y	N	Ulcers	Y	N	*Head Problems
Y	N	High/Low Blood Pressure	Y	N	Ruptures	Y	N	Depression
Y	N	*Diabetes	Y	N	Coughing Blood	Y	N	Tumors

* Explanation: _____

_____

_____

WHEN WAS YOUR LAST PHYSICAL EXAM? _____

WHEN WAS THE LAST TIME YOU WERE INVOLVED IN AN ACCIDENT OF ANY KIND? _____

FOR DOCTOR'S USE ONLY

❑ GENERAL

INJURY TYPE:

MEDICATION LIST

NAMES OF MEDICATION	NAMES OF VITAMINS	NON-Rx STRENGTH	Rx STRENGTH	DATE STARTED	DATE STOPPED	WHO PRESCRIBED DR. / SELF	
						D	S
						D	S
						D	S
						D	S
						D	S

❑ NDRA

DRUG ALLERGIES:

❑ SEE MEDS ADDENDUM

DATE: _____

ACCT: _____

PATIENT: _____

SYSTEMS REVIEW

In the left-hand column, please indicate with a (C) Conditions you have now or with a (P) the conditions you have had in the Past. If neither apply, mark (NA), don't leave any blanks.

High Blood Pressure	____
Dizziness/Fainting	____
Insomnia	____
Low Resistance	____
Tension	____
Confusion	____
Fatigue	____
Ulcers	____
Eye/Vision Problems	____
Ear/Hearing Problems	____
Difficulty Breathing	____
Heart Problems	____
Loss of Bladder Control	____
Constipation	____
Diarrhea	____
Digestion Problems	____
Nausea	____
Female Problems	____
Prostate Problems	____
Diabetes	____
Hands/Feet Cold	____
Hand Tremors	____
Loss of Memory	____
Nervousness	____
Sweaty Palms	____
Speech Difficulty	____
Anxiety	____
Depression	____
Irritability	____

FOR DOCTORS'S USE ONLY

DR. REVIEWED	SYSTEMS	SYMPTOMS
_____	General	Weight changes, fatigue, anorexia, weakness, fever, chills changes in activity
_____	Skin	Rashes, eruptions, changes in warts or moles, pigmentation changes, bruising, itching, hair loss, nail changes
_____	Head	Trauma, headaches, dizziness, light headed
_____	Eyes	Change in acuity of vision, use of corrective lensed, loss of diplopia, photophobia, blurred vision, scotomata, pain, excessive lacrimation, redness, discharge
_____	Nose	Rhinorrhea, epistaxis, allergies, airway obstruction
_____	Mouth & Throat	Ulcers, tooth pain/extractions, temporomandibular joint (TMJ) pain, gum bleeding, soreness, swelling, enlarged glands, sore throat, strep throat
_____	Neck	Stiffness, lumps/swelling/masses, pain
_____	Lungs	Cough (productive/nonproductive), hemoptysis, dyspnea, pain with respiration, wheezing, night sweats
_____	Cardiac	Palpitations, chest pain, orthopnea, paroxysmal nocturnal dyspnea, ankle swelling, syncope
_____	Vascular	Raynaud's phenomenon, intermittent claudication, hypertension, rheumatic fever
_____	Breasts	Self-examination frequency/results, pain, nipple discharge, lumps/masses, skin dimpling
_____	Gastrointestinal	Unusual diet, sysphagia, regurgitation, dyspepsia, nausia, vomiting, belching, abdominal pain, cramps, hematemasis, stool color changes, diarrhea, constipation, change in bowel habits, jaundice, abdominal swelling
_____	Genitourinary	Polyuria, nocturia, oliguria, cysuria, uregency, incontinence, urine color changes, hematurea, sexually transmitted diseases, dyspareunia, scrotal mass (male), hernia
_____	Endocrine	Polydipsia, polyphagia, temperature intolerance, tremors, goiter, alopecia, hirsuitism, menstration, history, pregnancy history, dysmenorrhea, premenstrual syndrome, climacteric
_____	Hematopoietic	Anemia, abdominal bleeding, lymph node elargement/pain
_____	Musculoskelatal	Bone/Joint pain, swelling, joint deformity, trauma, restricted range of motion, weakness, atrophy
_____	Neurological	Cranial nerve deficits, seizures, loss of consciousness, paralysis, tremors, staxis, loss of balance, numbness, parasthesia
_____	Psychological	Mood swings, depression, anxiety, phobias

Please identify all facilities/providers you have seen for these conditions and those you are currently seeing, if any, for your presenting problem(s)

PROBLEM LIST

DR NAME/ FACILITY	PROBLEM	TYPE OF TREATMENT RECIEVED	FROM WHEN TO WHEN

FOR DOCTORS USE ONLY

- ❑ Reviewed External H P
- ❑ Release Records H P
- ❑ Request Records H P

EXTERNAL DX'D: _____

DISABILITIES:

IMPAIRMENTS:

DATE: _____
ACCT: _____
PATIENT: _____

PATIENT HISTORY

1. What is your **main complaint**? _____
2. On the scale below, please **circle** the **severity** of your **main complaint** (At it's worst)

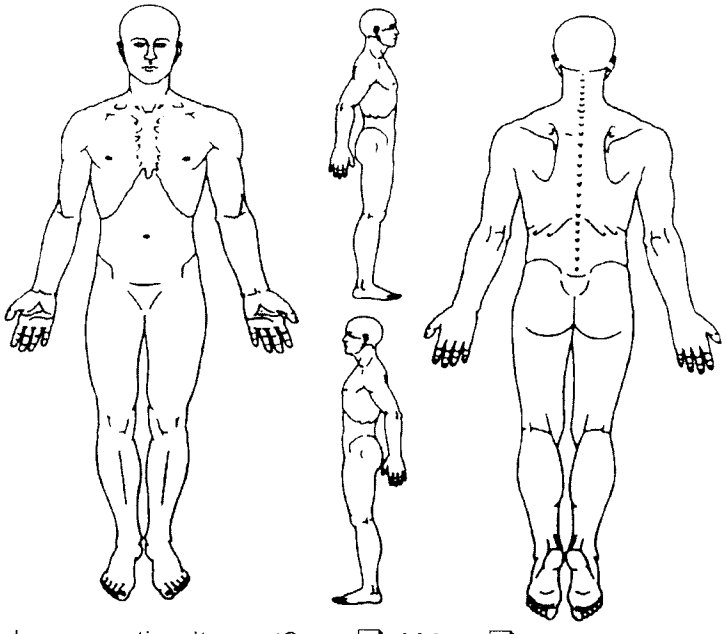
None		*Slight*		*Mild*		*Moderate*			*Severe*
1	2	3	4	5	6	7	8	9	10

3. On the scale below please **circle** the **percentage of time** you experience your **main complaint:**

	Occasional			*Intermittent*			*Frequent*			*Constant*	
0	10	20	30	40	50	60	70	80	90	100	%

4. How **long** have you been experiencing your **main complaint?** _____
5. On the diagram below, please show **where** you are experiencing **all** of your present complaints using the following letters:

A: ache **B:** burning pain **C:** cramping **D:** dull pain **R:** throbbing pain **N:** numbness **T:** tingling



6. When do you notice it most? ❑ AM ❑ PM
   How long does it last? _____Mins _____Hrs
7. What makes it feel better? _____
8. What makes it feel worse? _____
9. Have you ever had this problem in the past? ❑ Yes ❑ No
10. I have ❑ been hospitalized ❑ been treated by another chiropractor ❑ been treated by another specialty provider ❑ never received care for this problem.
11. Have you lost time from work because of it? ❑ Yes ❑ No
    Dates?_____ to _____
12. Are you Pregnant? ❑ Yes ❑ No
13. What was the first day of your last menstrual cycle? _____
14. Number of pregnancies? _____ Miscarriages? _____

Do you have **pain** and/or **difficulty** performing any of the following activities: (Check)

personal care ____
lifting ____
reading ____
concentrating ____
work ____
driving ____
sleeping ____
recreation ____
walking ____
sitting ____
standing ____
social life ____

Signature:_____

Date: ____/____/____

Informed Consent for Chiropractic Treatment

Patient Name:_____

To the patient:

Please read this entire document prior to signing it, it is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The nature of the chiropractic adjustment:

The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you; I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click" much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis/Examination/Treatment:

As part of the analysis, examination, and treatment you are consenting to all the following possible procedures.

Please initial next to the procedures below:

Spinal manipulative therapy _____ Orthopedic testing_____

Palpation_____ Range of motion testing_____

Postural analysis_____ Cold/hot therapy_____

Muscle strength testing_____ Vital signs_____

Myofascial release_____ Basic neurological testing_____

Cold laser therapy_____ Percussion therapy_____

Other (please explain)_____

The material risks inherent in chiropractic adjustment:

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include, but are not limited to: fracture, disc injuries, dislocations, muscle strain, cervical myslopathy, costrovertebral stains, and separations, and bruises. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

The probability of those risk occurring:

Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during taking your history and during examination, stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one on one million and one in five million cervical adjustments. The other complications are generally described as rare.

The availability and nature of other treatment options,

Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain killers
- Hospitalization
- Surgery

If you choose to use the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risk and dangers attendant to remaining untreated:

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE. PLEASE CHECK THE APPPROPRIATE BLOCK AND SIGN BELOW.

I have read [ ] or have had read to me [ ] the above explanation of the chiropractic adjustment and related treatment. I have discussed any questions or concerns with Dr. Stevanie Bahnerth and had them answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Date: _____ Date: _____

_____ _____

Patient's Name Doctor's Name

_____ _____

Signature Signature

_____

Signature of Parent or Guardian (if a minor)

PATIENT CONSENT FORM

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for **Healthy Images** to use and disclose protected health information (PHI) about me to carry out treatment, payment, and health care operations (TPO). (The Notice of Privacy Practices provided by **Healthy Images** describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. **Healthy Images** reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to **Healthy Images**, **29455 N. Cave Creek Rd. Ste 124, Cave Creek, Arizona 85331.**

With this consent, **Healthy Images** may call my home or alternative location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, **Healthy Images** may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential."

With this consent, **Healthy Images** may email to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that **Healthy Images** restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow **Healthy Images** to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, **Healthy Images** may decline to provide treatment to me.

Signed By: _____ _____ _____

Signature of Patient or Legal Guardian | Date | Relationship to Patient

_____ _____

Print Patients Name | Print Name of Legal Guardian, if applicable

Patient/Guardian must be provided with a signed copy of this authorization form.

Healthy Images
29455 N. Cave Creek Rd. Ste 124 **Phone: (480) 563-5006**
Cave Creek, AZ 85331