



Our goal is to help solve your health challenges with solutions that meet your needs directly.
Filling out this form with intention is a great start!

Name: _____ Date: _____

Cell number: _____ *Cell Phone Provider _____ (for appt reminder texts only).

Email _____ Mailing Address: _____

City/State: _____ Zip: _____

D.O.B: ____/____/____ Age: ____ Sex: M F

Soc. Sec. #: _____ - _____ - _____

1. What is the health/body problem you are wishing to resolve and/or halt the progression of

_____?

2. How does it affect your Quality of Life ?

a) How does this problem negatively affect the quality of your life?

b) What are a couple of ways your life would improve if this problem was resolved ?

3. Are your symptoms and/or loss of function worsening and or becoming more persistent ?

Please describe _____

4. What have you tried so far to resolve this health/body problem ?

Please check those that apply

- ☐ Surgery
- ☐ Medication
- ☐ Physical Therapy
- ☐ Massage
- ☐ Stretching
- ☐ Acupuncture
- ☐ Exercises
- ☐ Other Chiro

5. Are you here for health benefits other than resolving a specific health/body problem?

Please check those that apply

- ☐ Chiropractic /Spinal Wellness.
- ☐ To increase energy and sports performance
- ☐ To ensure a Healthy Pregnancy.
- ☐ To ensure a healthy active aging process.
- ☐ To manage stress more effectively.
- ☐ To lose weight.

6. Please tell us more about your specific health/body problem.

1. When did your primary symptom first occur? _____.

2. Was there a trauma or incident related to the onset of these symptoms ? **Yes / No**

If yes please describe:_____.

3. Is there a stressor that elicits the symptom or pattern?

_____.

4. How many times have you had a similar symptom or pattern?

_____.

5. Are the episodes the same? Or are they intensifying ? If they are intensifying how so ?

- ☐ Severity if so how so _____.
- ☐ Duration if so how so _____.
- ☐ Frequency if so how so _____.

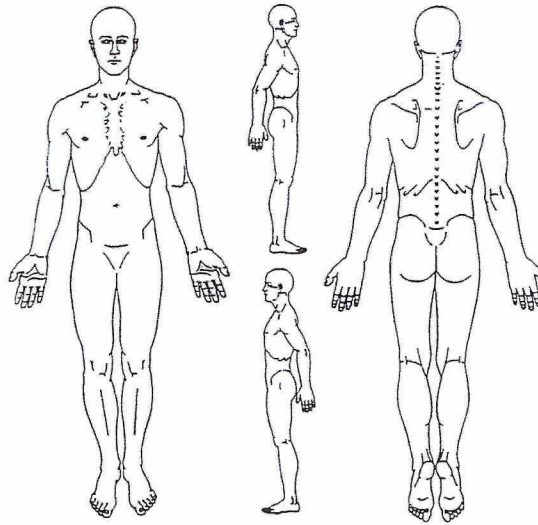
6. Please tell us about any other details about your overall health?

- ☐ Any related surgeries _____
- ☐ Current medications _____
- ☐ Exercise frequency _____
- ☐ Exercise Intensity _____
- ☐ Other _____

Please draw location of your symptoms and the type of symptom you are experiencing
 (Circle location and label with the appropriate pain quality)

Symptom Type

- A = Ache
- B = Burning
- N = Numb
- T = Tingling
- SHA = Sharp
- SP = Spasm
- W = Weak



Frequency: How often do these symptoms occur? _____.

Duration: How long does it last? _____.

Severity: On a 1 - 10 scale (_____).

Dr. Notes

HIPAA: PRIVACY CONFIDENTIALITY STATEMENT

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

DISCLOSURE OF INFORMATION:

We may disclose information to other healthcare professionals and/or your insurance carrier for treatment, payment or healthcare operations. Additional disclosures may be necessary to comply with Workers' Compensation and Public Health Laws as well as judicial proceedings. We may contact a family member or other authorized person in the event of an emergency. Be assured that we will not disclose any information without your expressed written consent unless compelled to do so by legal authority. Further you will be contacted by phone or mail in the event a request for information is made.

APPOINTMENT REMINDER:

It is our policy to call your home or office prior to your scheduled appointment to remind you of your appointment time. If you are not available, we leave a message on your voicemail or with the person answering the phone. We will not leave any message that discloses confidential information. If you would like to use an alternative contact number, please inform us of the number you would prefer.

FACILITY SET-UP:

While our treatment, massage and acupuncture rooms are private, this office does not have floor to ceiling walls. This provides a somewhat 'open concept'. The Doctor and Staff will maintain policies to ensure privacy and confidentiality, but there is a possibility for inadvertent discussions about your care, payment options, and insurance billing while in our office. If there is private information that you need to discuss, please request such information to be private and we will do everything we can to meet your confidential needs.

YOUR RIGHTS:

- ❖ You have the right to inspect and have a copy of your health information. There is no cost for the first copy; however, any copy thereafter will be \$25.
- ❖ You have a right to amend your information. Please note that we have the right to disagree with your amendments. If there is a disagreement you will be provided with information about our denial of your amendment and how you may appeal the denial of amendment. ❖ Request that we communicate with you about medical matters using reasonable alternative means or at an alternative address. ❖ Receive an accounting of our disclosures of your medical information, except when those disclosures are made for treatment, payment or health care operations, or the law otherwise restricts the accounting.
- ❖ Request additional restrictions on uses and disclosures of your health information. We are not required to agree to these requests and in some instances your requests may be prohibited by law.
- ❖ Send us a written request to see or procure a copy of the information that we have about you, or amend your personal information that you believe is incomplete or inaccurate. If we did not create the information we will refer you to the source, such as other doctors or hospitals.

COMPLAINTS:

Complaints about your privacy rights or how your privacy is handled at this office can be directed to the Office Manager or Dr. J. Scott Threde by calling this office during our regular business hours. If you are not satisfied with how this office handles your complaint you may submit a formal complaint to:

DHHS (Office of Civil Rights) 200 Independence Ave., S.W.
Room 509F, HHH Building Washington, DC 20201

I have read this Privacy Notice and understand my rights contained in this notice. By signing this form, I provide authorization and consent to use and disclose my protected health information as noted above.

X Patient Name: _____ X Patient Signature: _____ Date: _____

Signature of Parent of Guardian: _____ Date: _____

Informed Consent Form

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and massage, on me (or on the patient name below, for whom I am legally responsible) by the doctor of chiropractic named below and/or licensed doctors of chiropractic who now or in the future work at the clinic or office listed above.

I have had the opportunity to discuss with the Doctor of Chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

Though rare, 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 soreness, fractures, disc injuries, strokes, dislocations and sprains. I realize the doctor will be doing a screening and exam for any risk concerns however I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

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

X Print Patient Name _____

X Patient Signature _____ Date _____

Witness//Doctor Signature _____ Date _____

Doctor /Staff Only!

Objective

George's' (Negative)/(Positive) _____.

Cervical

Subluxations:

C1 (L / R) C2 (L / R) C3 (L / R) C4 (L / R) C5 (L/R) C6 (L / R) C7 (L / R) 1st Rib (L / R)

Muscle tension: Trapezius (L / R) Rhomboid (L / R) Teres (L / R) Pec Minor (L / R) TMJ (L / R)

Range Of Motion

Rotation Dec (L / R) ____/____degrees

Extension Dec ____degrees

Lateral Flex Dec (L / R) ____/____degrees

Arm Strength ____/5 (L / R) ____/____

Ortho Neuro (+) _____

Upper Extremities (+) _____

Thoracic

Subluxations:

T1 (L / R) T2 (L / R) T3 (L/R) T4 (L / R) T5 (L / R) T6 (L / R) T7 (L / R)

T8 (L / R) T9 (L / R) T10 (L / R) T11 (L / R) T12 (L / R)

Lumbar

Subluxations:

L1 (L / R) L2 (L / R) L3 (L / R) L4 (L / R) L5 (L / R) Sacrum (L / R)

Ortho Neuro

Sacral Comp Test (L / R) Piriformis (L / R) IT Band (L / R) Calf (L / R)

Hamstring Short: (L / R) ____/____degrees

Leg Check Short: (L / R) ____"

Milgram's Test Pos (L / R) ____ describe _____.

Internal Hip Rotation Limited Decreased (L / R) ____

Leg Strength ____/5 (L / R) ____/____

Other Ortho Neuro Findings (+) _____

Lower Extremities Findings (+) _____

Proposed Treatment Plan: ____/____/____ : ____/____/____