ADULT APPLICATION FOR CARE
COLUMBIA FAMILY CHIROPRACTIC

WELCOME TO OUR PRACTICE!

Today's Date: _____ ***Who can we thank for referring you to this office?_____***

PATIENT DEMOGRAPHIC

Name: _____ Birth Date: _____-_____-_____ Age: _____ ❑ Male ❑ Female

Address: _____ City: _____ State: _____ Zip: _____

E-mail Address: _____ Mobile or Preferred Phone Number:_____

Marital Status: ❑ Single ❑ Married Insurance: ❑ Yes ❑ No ❑ Military (active or veteran)

Social Security #: _____ Driver's License #: _____

Employer: _____ Occupation: _____

Spouse's Name: _____ Spouse's Employer: _____

Number of children:_____ Ages: _____

Emergency Contact Name : _____Number:_____Relationship: _____

Primary Care Physician: _____

INSURANCE INFORMATION

Primary Insurance:_____Policy Number: _____

Policy Holder Name:_____ Policy Holder DOB: _____

Secondary Insurance: _____ Policy Number: _____

Policy Holder Name:_____ Policy Holder DOB: _____

HISTORY of COMPLAINT

Please identify the condition(s) that brought you to this office:

Primary complaint: _____

Secondary complaint: _____

Additional complaint: _____

When did the conditions(s) begin? _____

Has the condition(s) ever been treated by a **Chiropractor** in the past?

❑ No ❑ Yes

Provider name: _____

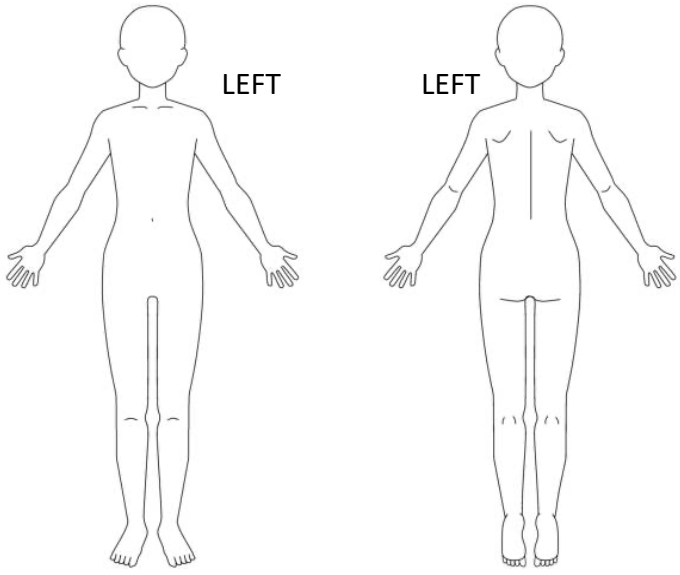
How long ago? _____

Duration of Treatment? _____ weeks | months | years

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

R = Radiating **B = B**urning **D = D**ull **A =** Aching

N = Numbness **S = S**harp/ **S**tabbing **T= T**ingling



Has the condition(s) been treated by any **other provider**? _____; _____
(type) *(provider)*

What were the results? ❑ Favorable ❑ Unfavorable

Brief explanation: _____

When is the problem at its worst? ❑ Morning ❑ Mid-day ❑ Evening ❑ Overnight

How long does it last? ❑ It is constant **OR** ❑ I experience it on and off during the day **OR** ❑ It comes and goes throughout the week

What have you done to try to relieve symptoms? _____
Example: Prescription medication, over the counter medications, homeopathic remedies, ice, heat, etc.

What makes your symptoms feel worse? _____

Is your condition the result of an automobile or work-related accident? ❑ Yes ❑ No If **yes**, please describe: _____

Is your condition the result of an injury? ❑ Yes ❑ No If **yes**, please describe what occurred: _____

Is there anything else you think your doctor should be aware of? _____

EFFECTS OF DAILY LIVING

Please identify how your current condition is affecting your ability to carry out activities that are routinely a part of your life:

Activity	100% function	75% function	35% function	0% function
Bending	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Carrying	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Concentrating	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Doing Chores	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Doing Computer Work	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Dressing	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Driving	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Lifting	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Pushing	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Rolling Over	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Running	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Sitting	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Sitting to Standing	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Sleeping	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Standing	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Walking	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Working	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Playing Sports/Dancing	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Recreational Activities	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform

FAMILY HISTORY

Some health issues are hereditary. Tell us about the health of your immediate family members:

Relative	Age (If Living):	State of Health: Good	State of Health: Poor	Illnesses:	Age at Death:	Cause of Death: Natural	Cause of Death: Illness
Mother		☐	☐			☐	☐
Father		☐	☐			☐	☐
Brother		☐	☐			☐	☐
Sister		☐	☐			☐	☐
		☐	☐			☐	☐

PAST HISTORY

PLEASE MARK OR USE DROP DOWN TO SELECT **"P"** FOR PAST, **"C"** FOR CURRENT, AND **"N"** FOR NEVER FOR EACH OF THE FOLLOWING:

Constitutional	___	Malaise/Fatigue	___	Sudden Weight Loss/Gain	___	Weakness	___	Fever/Chills
Neurologic	___	Headaches	___	Lightheadedness/Dizziness	___	Seizures	___	Numbness/Tingling
Eyes/Ears/Nose	___	Visual Disturbances	___	Hearing Loss/Ringing in Ears	___	Chronic Sinus/Ear Infections	___	Jaw Pain/TMD
Respiratory	___	Asthma	___	COPD	___	Difficulty Breathing	___	Sleep Apnea
Cardiovascular	___	High Cholesterol	___	High/Low Blood Pressure	___	Heart Attack	___	TIA/Stroke
Gastric/Digestive	___	Constipation	___	Diarrhea	___	Digestive problems	___	Stomach aches
Urinary/Sexual	___	Incontinence	___	Urinary Tract Infections	___	Menstrual pain/irregularities	___	Sexual Dysfunction
Endocrine/Autoimmune	___	Diabetes	___	Thyroid Disorder	___	Fibromyalgia	___	Gout
Infectious	___	HIV/AIDs	___	Hepatitis	___	Herpes	___	Chickenpox/Shingles
Musculoskeletal	___	Osteoporosis	___	Swollen/Painful Joints	___	Broken Bone	___	Scoliosis
Skin	___	Eczema/Rash	___	Poor wound healing	___	Psoriasis	___	Acne
Psychiatric	___	ADD/ADHD	___	Depression/Anxiety	___	Difficulty Sleeping	___	Eating Disorder
Other	___	Alcoholism	___	Allergies	___	Cancer: _____	___	Pregnancy
Any other conditions we should be aware of:								

Any prescription & nonprescription medications: _____

Any past surgeries/procedures: _____

Any jobs you have had that have imposed any physical stress on you or your body:_____

Any medical equipment you use regularly (ex. Walker, back brace, etc.): _____

SOCIAL HISTORY

1. Tobacco Use: ❑ cigars/pipe/vape ❑ chewing ❑ cigarettes How often? ❑ Daily ❑ Weekly ❑ Occasionally ❑ Never

2. Alcohol Use: _____ How often? ❑ Daily ❑ Weekly ❑ Occasionally ❑ Never

3. Recreational drug Use: _____ How often? ❑ Daily ❑ Weekly ❑ Occasionally ❑ Never

4. Water Intake: How much? _____ oz/daily (1 cup = 8 oz)

5. Coffee Consumption: How much? _____ oz/daily (1 cup = 8 oz)

6. Soda Consumption: How much? _____ oz/daily (1 cup = 8 oz)

7. Sleep per night How much? _____ hrs/night

8. Hobbies/Recreational Activities/Exercise: How often? ❑ Daily ❑ 3-4x week ❑ 3-4x/month ❑ Never

9. Largest stressor in your life: _____

10. In addition to the main reason for your visit today, what additional health goals do you have? _____

ACKNOWLEDGEMENTS

Please read each statement and initial your agreement:

_____ I instruct the chiropractor to deliver the care that, in his or her professional judgement, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.

_____ I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive. I authorize payment to be made directly to Columbia Family Chiropractic for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments.

_____ To the best of my ability, the information I have supplied above is complete and truthful. I have not misrepresented the presence, severity, or cause of my health concern.

_____ _____

Patient or Authorized Person's Signature **Date Completed**

_____ _____

Doctor Signature **Date Form Reviewed**

Quadruple Visual Analogue Scale (QVAS)

Instructions: Please circle the number that best describes the question being asked

Primary Complaint: _____

1 – Rate your pain RIGHT NOW

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain

2 – Rate your TYPICAL OR AVERAGE pain

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain

3 – Rate your pain AT ITS WORST (How close to a "10" does your pain get?)

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain

4 – Rate your pain AT ITS BEST (How close to a "0" does your pain get?)

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain

Secondary Complaint: _____

1 – Rate your pain RIGHT NOW

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain

2 – Rate your TYPICAL OR AVERAGE pain

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain

3 – Rate your pain AT ITS WORST (How close to a "10" does your pain get?)

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain

4 – Rate your pain AT ITS BEST (How close to a "0" does your pain get?)

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain

Tertiary Complaint: _____

1 – Rate your pain RIGHT NOW

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain

2 – Rate your TYPICAL OR AVERAGE pain

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain

3 – Rate your pain AT ITS WORST (How close to a "10" does your pain get?)

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain

4 – Rate your pain AT ITS BEST (How close to a "0" does your pain get?)

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain

Comments: _____

Columbia Family Chiropractic's Notice of Privacy Practices

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your Personal Health Information. In addition, we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as dictated by statements below, we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. Once you have read this notice, please sign the bottom. **Please keep this page for your records.**

PERMITTED DISCLOSURES:

- **Treatment Purposes**: Discussion with other health care providers involved in your care.
- **Payment Purposes**: Use and share your health information to bill and get payment from insurance providers, health plans, or other entitles.
- **Phone Calls/Emails and Appointment Reminders**: We may call/email you and leave messages regarding a missed appointment or to update you of changes in practice hours or upcoming events.
- **Inadvertent Disclosures**: Open treatment areas mean open discussion, if you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room.
- **Workers Compensation Purposes**: To process a claim or aid in an investigation.
- **Respond to Lawsuits and Legal Actions**: Share health information about you in response to a court or administrative order, or in response to a subpoena.
- **Public Health and Safety:** In order to prevent or lessen a serious or imminent threat to the health or safety of a person or general public.
- **Government Agencies or Law Enforcement:** To share information about you if state or federal laws require it. Additionally, to identify or locate a suspect, fugitive, material witness or missing person.
- **For Military, National Security, Prisoner and Government Benefits Purposes.**
- **Emergency:** In the event of a medical emergency, we may notify a family member.
- **Deceased Persons:** For discussion with coroners and medical examiners in the event of a patient's death.
- **Change of Ownership:** In the event this practice is sold the new owners would have access to your PHI.

YOUR RIGHTS:

- To receive a paper copy of the comprehensive detailed privacy notice
- To receive an accounting of disclosures
- To request mailings to an address different than residence
- To request restrictions on certain uses and disclosures and with whom we release information to; although, we are not required to comply. If; however, we agree, the restriction will be in place until written notice of your intent to remove the restriction.
- To inspect or obtain a copy of your medical records or x-rays, usually within 30 days of your request. We may charge a reasonable, cost-based fee for copies of records and/or x-rays.
- To request amendments to information; however, like restrictions, we are not required to agree to them.
- To choose someone to act for you. If you have given someone medical power of attorney or someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- To file a complaint if you feel your rights are violated.

I understand my rights as well as the practice's duty to protect my health information and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this "Notice of Privacy Practice" at any time in the future and will make the new provisions effective for all information that it maintains past and present. If you wish to make a formal complaint about how we handle your health information, please call the office at (803) 888-6646.

I am aware that a more comprehensive version of this notice is available to me and can be requested at any time. At this time, I do not have any questions regarding my rights or any of the information I have received.

_____ _____

Patient Name (print) **DOB**

_____ _____ **Witness Initial** ☐

Patient Signature **Date**

Columbia Family Chiropractic's Office Policy

As a potential new patient, it is important that you understand our office policies regarding how patients of this practice are cared for, and the various methods we offer to facilitate payment for that care. Please read each policy carefully so there is no misunderstanding as to what you can expect as a patient of this practice, and what we expect in return. Once you have read 'Our Office Policies', if you have any questions or any of these policies are unclear to you, please let our receptionist know and a member of our staff will be happy to discuss them with you further. We believe it is in everyone's best interests to provide potential new patients as much information as possible about how the doctors at this office practice chiropractic so that an informed decision can be made as to whether they wish to become a patient.

Over time, individuals who are accepted as patients at this office, gain a greater understanding as to the purpose of chiropractic. Since the majority of patient care occurs in an open bay area, patients have a unique opportunity to observe firsthand the positive results that are achieved and the benefits derived from being under chiropractic care. This knowledge and awareness reap a positive environment that promotes healing and encourages families to maintain good health. We want your experience with us to be an exceptional one, so help us to help you and together we can make affirmative changes in your life and the lives of those you care about.

PATIENT PRIVACY – Since the majority of patient care takes place in an open bay area it is important to understand that any conversations you have with the doctor may be overheard by other patients. In order to maintain patient privacy, it is the policy of this practice to refrain from discussing any confidential matters with patients during treating hours while patients are being adjusted. If you have a confidential matter you wish to discuss please let us know and we will schedule time for you to speak to the doctor in a private consultation room. These consultations must be scheduled in advance.

YOUR CARE - When a patient seeks chiropractic health care and we agree to provide that care, it is essential for the patient and the doctor to be working toward the same objective. Chiropractic care at **Columbia Family Chiropractic** is rendered primarily to minimize and reduce subluxations, which are a major interference to the expression of the body's God-given, innate wisdom. The doctors use a myriad of techniques to accomplish this goal, including but not limited to Clear Institute, Pettibon, Full Spine, CBP, Toggle, Gonstead, and Activator. It is important that you understand both the objective and the method(s) so there is no confusion or disappointment. Your doctor will outline a course of treatment **specific to you** that will take you beyond simple pain relief. Through two distinct phases of care, our goal is to make structural correction to your spine that will enable your central nervous system to function optimally, thereby improving your overall health.

FIRST THINGS FIRST- Prior to receiving chiropractic care at this office, a health history and examination will be completed. Imaging studies as well as any other necessary diagnostics may also be ordered, to confirm the true nature of your condition and location of subluxations. The results of these procedures will aid in assessing your presenting problem, your overall health and, in particular, the condition of your spine. They will also assist the doctor in determining the type and amount of care you will need. All relevant findings will be reported to you along with care plan recommendations so that you can make the best possible decision regarding your health care needs. Our gold standard for care is to ensure the reduction of subluxation while teaching patients what they need to do in addition to being adjusted to maintain their health for a lifetime.

PATIENT'S REPORT OF FINDINGS – To enhance your understanding of the chiropractic approach that will be used to manage your health, immediately following your first adjustment, you will be scheduled for a 'Doctors Report of Findings'. The information you receive at this appointment will be both informative and clinically relevant to your case; therefore, attendance is required for individuals who wish to become new patients of this practice. Because the results of your x-rays and all examinations as well as the doctors' recommendations for care, will be discussed at that time, **we strongly urge new patients to invite their spouse or significant other to attend**. We know from experience that when a patient's family understands the goals and objectives of chiropractic care and how restoring and maintaining good health can affect their lives as well, they become infinitely supportive and helpful in making decisions concerning treatment options.

I hereby acknowledge receiving a copy of the practices "Office Policies". This page will be retained by the practice as evidence of my receiving and understanding this "Notice". I further acknowledge that any concerns regarding these "Policies" as well as all my questions have been answered by a qualified member of the staff to my complete satisfaction.

_____ _____

Patient Name (print) **DOB**

_____ _____ **Witness Initial** ☐

Patient Signature **Date**

INFORMED CONSENT

REGARDING: Exam, Chiropractic Adjustments, and Therapeutic Procedures

The nature of the chiropractic adjustment:

The primary treatment we use as Doctors of Chiropractic is spinal manipulative therapy. We will use that procedure to treat you. We may use our hands or a mechanical instrument upon your body in such a way as to move your joints. This 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 the following procedures:

- spinal manipulative therapy
- palpation
- range of motion testing
- orthopedic testing
- basic neurological testing
- muscle strength testing
- postural analysis
- EMS
- ultrasound
- radiographic studies
- 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: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations. 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 treatments. We will make every reasonable effort while taking your history and during examination and X-ray to screen for contraindications to care; however, if you have a condition that would otherwise not come to our attention, it is your responsibility to inform us.

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 prescriptions such as anti-inflammatories, muscle relaxants, and pain relievers; hospitalization; and surgery. If you chose to use one of 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 risks and dangers attendant to remaining untreated:

Remaining untreated may worsen condition, reduce mobility, or increase pain. Over time this may complicate treatment making it more difficult and less effective.

Incidental findings:

If during the course of spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis, or treatment for those findings we will recommend that you seek the services a health care provider who specializes in that area.

REGARDING: X-rays/Imaging Studies

During your examination, the doctor may feel that x-rays will be needed in order to provide your treatment. In order to perform x-rays on any patient our office requires that patients consent for such tests to be performed.

FEMALES ONLY: Please read carefully and complete below:

□ The first day of my last menstrual cycle was on ____/____/____ □ To the best of my knowledge, I am not pregnant

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE:

Treatment objectives as well as the risks associated with chiropractic adjustments and all other procedures provided at Columbia Family Chiropractic have been explained to me to my satisfaction.

I acknowledge the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays.

After careful consideration, I do hereby consent to a full examination and treatment by any means, method, and or techniques, the doctor deems necessary to determine and treat my condition at any time throughout the entire clinical course of my care.

_____ _____

Patient Name (print) **DOB**

_____ _____ **Witness Initial** ☐

Patient Signature **Date**

HIPAA Personal Health Information Release Authorization

Communication with Others:

I, _____, hereby authorize Columbia Family Chiropractic to discuss with and/or release information to the following people concerning my appointments, insurance, billing, and health treatment rendered.

- ☐ Spouse
- ☐ Parent/Legal Guardian
- ☐ Child(ren)
- ☐ Other Specified Person: _____
- ☐ Information is not to be discussed with or released to anyone

Restrictions:

- ☐ No Restriction
- ☐ Only discuss my appointment time with the above-named individual(s).
- ☐ Only discuss issues concerning my account, including insurance and/or billing with the above-named individual(s).
- ☐ Only discuss the health treatment rendered to me with the above-named individual(s).

Messages:

I authorize Columbia Family Chiropractic to call, text, email me regarding:

- Appointment Reminders/Scheduling
- Information Regarding Insurance/Billing
- Upcoming Events/Workshops
- Requests for Patient Satisfaction Online Reviews

I authorize such messages to be delivered to the following:

Preferred phone number: _____

Preferred email address: _____

I understand and acknowledge that electronic communication carries certain risks, including but not limited to unauthorized access, potential breaches of privacy, and transmission errors. Despite these risks, I wish to communicate with Columbia Family Chiropractic electronically for matters related to my medical care and records.

I acknowledge that Columbia Family Chiropractic will take reasonable precautions to protect the security and confidentiality of the information sent electronically, including using secure email systems and encryption where possible. However, I understand that Columbia Family Chiropractic cannot guarantee the absolute security of electronic communication.

I acknowledge I am responsible for providing the practice with any updates to my email address and/or phone number.

I understand I may terminate this consent at any time by giving written notice to Columbia Family Chiropractic.

_____ _____

Patient Name (print) **DOB**

_____ _____ **Witness Initial** ☐

Patient Signature **Date**