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: _____

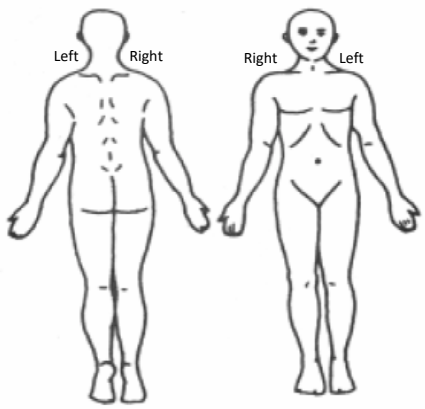
Secondary Insurance: _____ Policy Number: _____
Policy Holder Name:_____ Policy Holder DOB: _____

HISTORY of COMPLAINT

Please identify the condition(s) that brought you to this office:
On a scale of **0** to **10** with **10** being the worst pain and **0** being no pain, rate your above complaints by ***circling the number*:**

Primary complaint: _____ Pain Level: 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Secondary complaint: _____ Pain Level: 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Additional complaint: _____ Pain Level: 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

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



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? _____

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

PAST HISTORY

Check the illnesses you have had in the past or have now:

PLEASE MARK **"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/Chicken Pox/Shingles	__ Vaccines
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.): _____

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		❑	❑			❑	❑
		❑	❑			❑	❑

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. 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

Patient Name _____ Date _____

Please read carefully:

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

Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

Example:

	Headache			Neck			Low Back			
No pain										**worst possible pain**
0	**1**	**(2)**	**3**	**4**	**(5)**	**6**	**7**	**(8)**	**9**	**10**

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1 – What is your pain RIGHT NOW?

No pain										**worst possible pain**
0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

2 – What is your TYPICAL or AVERAGE pain?

No pain										**worst possible pain**
0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

3 – What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?

No pain										**worst possible pain**
0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

4 – What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?

No pain										**worst possible pain**
0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

OTHER COMMENTS:

_____

_____

_____

Examiner

Reprinted from *Spine*, 18, Von Korff M, Deyo RA, Cherkin D, Barlow SF, Back pain in primary care: Outcomes at 1 year, 855-862, 1993, with permission from Elsevier Science.

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 records, usually within 30 days of your request. We may charge a reasonable, cost-based fee for a copy. X-rays are original records, and you are therefore not intitled to them. If you would like us to outsource them to have copies made, we will be happy to accommodate you. However, you will be responsible for this cost.
- 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 choice about your health information.
- To file a complaint if you feel your right 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. Tremendous progress has been made in the rehabilitating and correction of spinal problems. 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 wished 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 objects of chiropractic care and how restoring and maintaining good health can affect their lives as well, they become infinitely supportive and helpful in making important 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 during the examination 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 probability of those risks occurring:

Fractures are rare occurrences and generally result from some underlying weakness of the bone which we will check for while taking your history and during examination and X-ray. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also 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 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:

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, 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 of the health care provider who specializes in that area.

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, and I have conveyed my understanding of both to the doctor(s). 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**

(Continued on back page)

INFORMED CONSENT CONTINUED

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 check the boxes, include the appropriate date, then sign above if you understand and have no further questions, otherwise see our receptionist for further explanation.

□ The first day of my last menstrual cycle was on ____/____/____
Date

□ I have been provided a full explanation of when I am mostly likely to become pregnant, and to the best of my knowledge, I am not pregnant.

By my signature below I am acknowledging that the doctor and/or a member of the staff has discussed with me 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 therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

_____ _____
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**