PETE'S CHIROPRACTIC, PA

Name _____ Date_____

Address_____

City, State_____ Zip Code_____ Phone Number_____

Email address _____
(Your email address will be used as our primary means of contact)

Would you like to receive our email we send out when there are changes to the hours? ☐ Yes ☐ No

Emergency contact & his or her phone #_____

Date of Birth _____ / _____ / _____ Age _____ Gender ☐ M ☐ F

Presently Employed? ☐ Yes ☐ No If yes, what do you do? _____

Married? ☐ Yes ☐ No If yes, partners name _____

Children? ☐ Yes ☐ No If yes, please list their names and ages below:

Name _____ Age _____ Name _____ Age _____

Name _____ Age _____ Name _____ Age _____

Name _____ Age _____ Name _____ Age _____

Have you ever been adjusted by a Chiropractor before? ☐ Yes ☐ No

If yes, when was your last visit? _____

If you can remember the name(s) of the chiropractor(s) you have been to please list their name(s) or the name of their office(s). _____

What brings you into the office? _____

_____

_____

_____

_____

What is your objective in coming here? _____

_____

_____

Medical Physician's Name _____

Have you had any surgeries, falls, broken bones, accidents or injuries? ☐ Yes ☐ No If yes, please explain and include dates. _____

_____

_____

_____

_____

_____

_____

How would you rate the quality of sleep you get on a 1-10 scale? (1 being poor and 10 being excellent) _____

How would you rate the quality of exercise you get on a 1-10 scale? (1 being poor and 10 being excellent) _____

How would you rate how you eat on a 1-10 scale? (1 being poor and 10 being excellent) _____

How would you rate your emotional stress level on a 1-10 scale? (1 being very stressed and 10 not stressed) _____

Do you take any prescription or non-prescription medications? If yes, list the drug, the purpose and length of time on them.
(examples: blood pressure medication, blood thinners, pain killers, cholesterol medication, muscle relaxers, tranquilizers, insulin, anti-depressants)

_____

_____

_____

_____

Do you smoke? ☐ Yes ☐ No

Is there any additional information regarding your medical history that you think we should know? _____

_____

_____

_____

What do you like to do for fun in your free time? _____

_____

How did you find out about the office?
(Please check all that apply)

☐ Flyer in the mail ☐ Internet ☐ Sign ☐ Facebook Ad ☐ Referred by a friend/relative ☐ Word of mouth

If you were referred please tell us who referred you so we can thank them_____

PHILOSOPHICAL AGREEMENT

DEFINING THE TERMS OF ACCEPTANCE

When a person seeks the services of a chiropractor it is absolutely essential to fully understand the objectives of that particular chiropractor.

It is not the goal or intention of ***Pete's Chiropractic, PA*** to diagnose, treat, or attempt to cure any physical, mental, or emotional ailments, or to give advice about any ailments.

The only objective of this office is to help keep your body as free as possible from vertebral subluxations (bones of your spine that are out of place and putting pressure on your nerves). We do this because your body will simply work better when vertebral subluxations are limited in size and number.

I _____ (please print full name)
choose to receive chiropractic for myself and my minor children (listed below) on the understanding of and agreement with the above scope of practice.

(Please list children 17 and younger)

_____ age_____ _____ age_____

_____ age_____ _____ age_____

_____ age_____ _____ age_____

Signature _____ Date _____

Notice of Privacy Policy

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment or practice operations will be made only after obtaining your consent.

-You may request restrictions on your disclosures.
-You may inspect and receive copies of your records within 30 days with a request.
-You may request to view changes to your records.
-In the future, we may contact you for appointment reminders, announcements and to inform you about our practice and its staff.

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

-Conduct, plan and direct my treatment and follow up with multiple healthcare providers who may be involved in that treatment directly or indirectly.
-Obtain payment from third party payers.
-Conduct normal healthcare operations such as quality assessments and physician's certifications.

I have read and understand your Notice of Privacy Practices. A more complete description can be requested. I also understand that I can request, in writing, that you restrict how my personal information is used and or disclosed.

Name (please print full name) _____

Signature _____ Date _____

Pete's Chiropractic, P.A.
Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an "arterial dissection" that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes
caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately a percentage of these patients will experience a stroke.

The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was
1219 events/ per one million persons/year and risk of death has been estimated as 104 per one million users.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: _____ Signature: _____ Date:

Parent or Guardian: _____ Signature:_____ Date:

Witness Name: _____ Signature:_____ Date:

Pete's Chiropractic, P.A. | 516 Washington Street S. | Northfield, MN 55057 |
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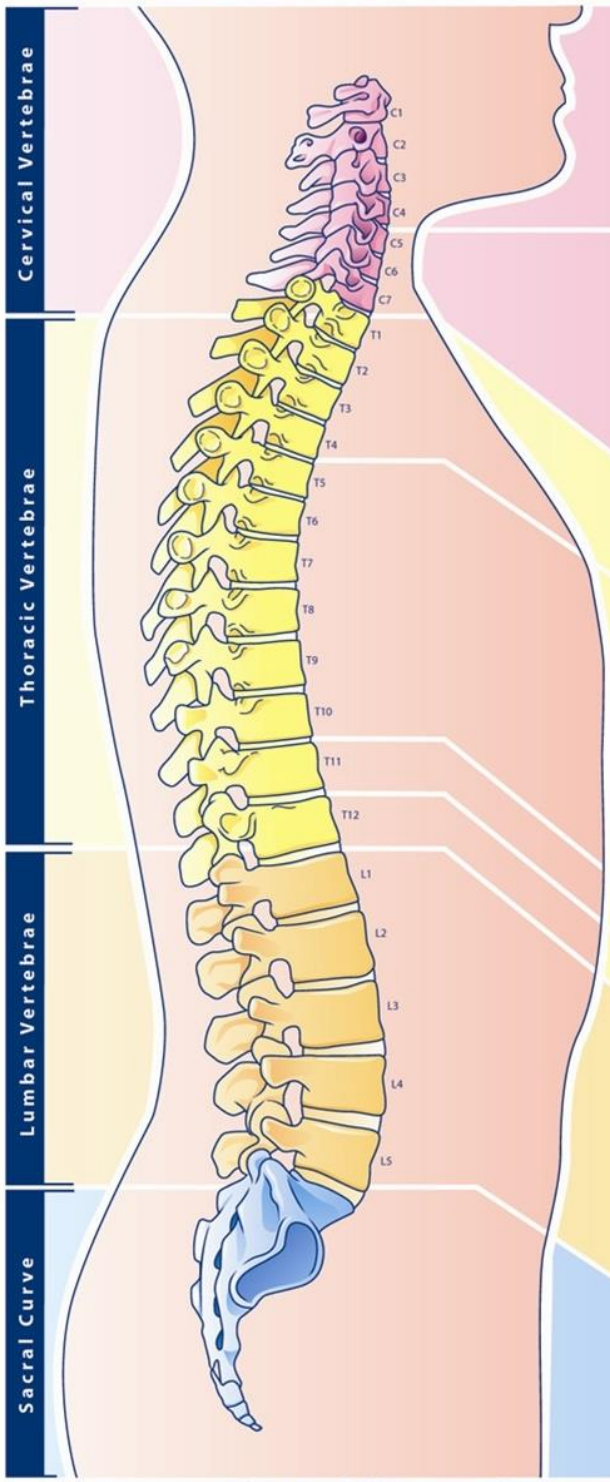
Instructions: Please circle any possible symptoms you may be experiencing or have experienced in the past few months and any areas of your body that are of concern to you.

Example: You have a heart condition and high blood pressure so you circle those under possible symptoms along with the heart under innervation.

Spinal Nerve Function

Your brain controls every cell in your body through spinal nerves



VERTEBRAL LEVEL	NERVE ROOT	INNERVATION	POSSIBLE SYMPTOMS
Cervical Vertebrae	C1 C2 C3 C4	Intracranial Blood Vessels I Eyes I Lacrimal Gland I Parotid Gland I Scalp I Base of Skull Neck Muscles I Diaphragm	Migraine Headaches Headaches I Dizziness Sinus Problems I Allergies Head Colds I Fatigue Vision Problems Runny Nose I Sore Throat Stiff Neck I Cough I Croup Arm Pain I Hand and Finger Numbness or Tingling I Asthma Heart Conditions High Blood Pressure
	C5 C6 C7 C8	Neck Muscles I Shoulders I Elbows I Arms Wrists I Hands I Fingers I Esophagus I Heart Lungs I Chest	
Thoracic Vertebrae	T1 T2 T3 T4	Arms I Esophagus I Heart Lungs I Chest I Larynx I Trachea	Wrist, Hand and Finger Numbness or Pain Middle Back Pain Congestion I Difficulty Breathing I Asthma High Blood Pressure Heart Conditions Bronchitis I Pneumonia Gallbladder Conditions Jaundice I Liver Conditions I Stomach Problems Ulcers I Gastritis Kidney Problems
	T5 T6 T7 T8 T9 T10	Gallbladder I Liver I Diaphragm Stomach I Pancreas I Spleen I Kidneys Small Intestine I Appendix I Adrenals	
	T11	Small Intestines I Colon I Uterus	
	T12	Colon I Uterus I Buttocks	
Lumbar Vertebrae	L1 L2 L3 L4 L5	Large Intestines I Buttocks I Groin Reproductive Organs I Colon I Thighs Knees I Legs I Feet	Constipation I Colitis Diarrhea I Gas Pain Irritable Bowel I Bladder Problems I Menstrual Problems I Low Back Pain Pain or Numbness in Legs
Sacral Curve	SACRAL	Buttocks I Reproductive Organs I Bladder Prostate Gland I Legs I Ankles I Feet I Toes	Constipation I Diarrhea Bladder Problems Lower Back Pain I Pain or Numbness in Legs

Reference: Haines, DE, PhD, Neuroanatomy, 7th Edition, Lippincott Williams & Wilkins, 2007 : Kandel, ER, et al, Principles of Neural Science, Appleton & Lange, 1991
Hoppenfeld, S, MD, Physical Examination of the Spine & Extremities, Appleton-Century-Crofts, 1976 ; Netter, FH, MD, Atlas of Human Anatomy, 4th Edition, Saunders, 2006