Welcome To Our Office

TODAY'S DATE _____

About You

Thank you for choosing our office.
*In order to serve you properly we will need the following information (**Please print.**) All information will be kept strictly confidential.*

Patient's name			Birthdate	Age	Home Phone
Residence address	City	State	Zip		Marital Status Single ☐ Married ☐ Divorced ☐ Widowed ☐
Social security number		E-mail			Cell Phone
Name of employer	Address		Occupation		Business phone

If child, parent's name or guardian's name

Ladies, in the event that you may need an X-ray, are you pregnant?

Insurance Info

Do you have medical insurance? ☐ Yes ☐ No	If not, how do you intend to pay? ☐ Check ☐ Cash ☐ Credit card	Ins. Co. name
Insured name		Patient's Relationship to Insured
Complete the following if you are **NOT** the insured	Insured's Birthdate	Insured's Social Security Number
Insured's Employer		Work Phone Number of Insured
Is there secondary Ins.? ☐ Yes ☐ No	Secondary Insurance Company Name	Insured name

Accident Info

Is this visit the result of an accident? Yes ☐ No ☐ ☐ Auto Collision ☐ Personal Injury

Is this visit the result of a work injury? Yes ☐ No ☐

Whom may we thank for referring you?

I authorize this office to release any information necessary to expedite insurance claims. I understand that I am responsible for all charges, regardless of insurance coverage. I authorize payment of medical benefits to Community Chiropractic Center.

Patient, Parent, or Guardian Signature _____ Date _____

Please turn over and complete backside

Community Chiropractic Center
Dane Schepp, D.C.
1501 East Sumner Street
Hartford, WI 53027
(262) 673-7600

INFORMED CONSENT TO CHIROPRACTIC SPINAL MANIPULATION

The nature of chiropractic treatment: The doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a "click" or "pop" such as the noise when a knuckle is "cracked" and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electrical stimulation, therapeutic ultrasound, or traction may also be used.

Possible risks: As with any healthcare procedure, complications are possible following a chiropractic manipulation. Complications are quite rare and could include fractures of bone, muscular strain, dislocation of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury, or stroke, could occur in very rare instances. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedure could procedure skin irritations, burns, or other minor complications.

Probability of risks occurring: The risks of complications due to chiropractic treatment have been described as "rare", about as often as complications are seen from taking a single aspirin tablet. The risk of cerebrovascular injury, or stroke, has been estimated at one in one million to one in ten million, and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered "rare".

Other treatment options that could be considered may include the following:

- *Over the counter analgesics.* The risks of these medications include irritations to stomach, liver, kidneys, and other side effects in a significant number of cases.
- *Medical care,* typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include undesirable side effects and patient dependence in a significant number of cases.
- *Hospitalization* in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.
- *Surgery* in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue, and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probably that delay of treatment will complicate the condition, and make future rehabilitation more difficult.

I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and hereby give my full consent to chiropractic manipulative therapy.

Printed Name	Signature	Date

COMMUNITY CHIROPRACTIC CENTER

CONSENT FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Our Privacy Pledge

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health care information.

- We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your health information within our practice for quality control or other operational purposes.

Along with this consent form, you will be given a copy of our privacy notice that describes our privacy policies in detail. You have the right to review that notice before you sign this consent form. We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail.

Your right to limit uses or disclosures

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

Your right to revoke your authorization

You may revoke any of your authorizations at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

I have read your consent policy and agree to its terms. I am also acknowledging that I have received a copy of this consent form and a copy of your privacy notice (Notice of Privacy Practices for Protected Health Information).

	DANE SCHEPP, DC
Printed Name	Authorized Provider Representative
	7-1-11
Signature	Date
Date	

PATIENT HEALTH QUESTIONNAIRE

NAME: _____ **DATE:** _____

1. Please Describe Your Complaint: _____

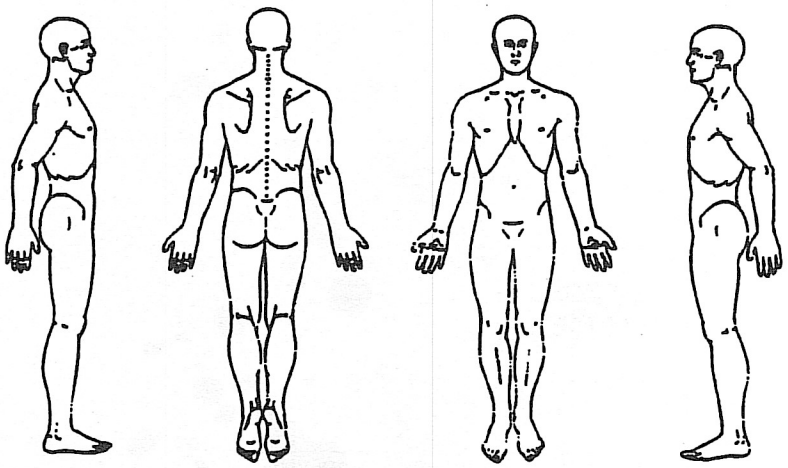
_____

_____

a. Description:
- ☐ Sharp Pain
- ☐ Dull Pain
- ☐ Ache
- ☐ Weak
- ☐ Throbbing
- ☐ Numb
- ☐ Shooting
- ☐ Burning
- ☐ Tingling

b. Frequency:
- ☐ Constant (76-100%)
- ☐ Frequent (51-75%)
- ☐ Occasional (26-50%)
- ☐ Intermittent (25% or less)

MARK ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS.



c. Indicate intensity of your pain at its lowest and highest level: **No Pain** [1] [2] [3] [4] [5] [6] [7] [8] [9] [10] **Unbearable Pain**

2. When did your problem begin: (specific date if possible) _____
Briefly describe how your problem began: _____

_____

3. Have you been treated *for this episode?* ☐ Yes ☐ No
If yes, by whom? ☐ Chiropractor ☐ MD ☐ Osteopath ☐ Physical Therapist ☐ Occupational Therapist ☐ Other _____
Are you currently being seen? ☐ Yes ☐ No

4. *In the past* have you been treated for the same or a similar problem? ☐ Yes ☐ No
If yes, who did you see for that episode? ☐ Chiropractor ☐ MD ☐ Osteopath ☐ Physical Therapist
☐ Occupational Therapist ☐ Other _____

5. How would you rate your stress level? ☐ Little or no stress ☐ Minimal Stress ☐ Moderate Stress ☐ Greatly Stressed

6. How are your complaints affecting your ability to be active?
- ☐ No effect
- ☐ Need limited assistance with common everyday tasks
- ☐ Some physical restrictions *(able to perform light duty work and household tasks)*
- ☐ Need assistance often.
- ☐ Have a significant inability to function without assistance.
- ☐ Am totally disabled (impaired). Cannot care for self.

7. What is your current work status?
- ☐ Full time, no restrictions
- ☐ Full time, with restrictions.
- ☐ Part time, no restrictions.
- ☐ Part time, with restrictions
- ☐ Off work due to restrictions
- ☐ Full time homemaker.
- ☐ Unemployed
- ☐ Retired
- ☐ Full time student.
- ☐ Other: _____