Davis Family Chiropractic

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Web: DavisFamilyChiropracticOhio.com

Confidential Case History

Patient Information:

Date:_____

Name:_____

Last First MI

Address:_____

Number & Street P.O. Box. City State Zip

Telephone:(Home)_____(Cell)_____(Work)_____

☐ Check this box to OPT OUT of receiving SMS text messages for appointment reminders.

Email Address:_____

☐ Check this box to OPT OUT of receiving our email newsletter.

Date of Birth:_____/_____/_____ Age:_____

Gender: ☐ M ☐ F Marital Status: ☐ S ☐ M ☐ D ☐ W Number of Children:_____

Occupation:_____

Employer:_____ Address:_____

NEAREST FRIEND OR RELATIVE WHO MAY BE CONTACTED IN CASE OF AN EMERGENCY:

Name:_____ Phone:_____

How did you hear about us?:_____

Is your condition the result of an accident or job-related injury? ☐ Yes ☐ No

POLICY REGARDING PAYMENT AND INSURANCE REIMBURSEMENT

I understand and agree that I'm paying Davis Family Chiropractic (DFC) for all services rendered at the time of service. DFC provides expert health knowledge, guidance, opinion on your healthcare, and holistic treatments. DFC is dedicated to keeping you, the client, as healthy as possible. Furthermore, I understand that because of this pay-for-fee service, absolutely no health information will be given to your insurance provider without your written consent. If you do have insurance other than Medicare or Medicaid, Davis Family Chiropractic will provide you a receipt for services rendered that you can submit to your insurance for possible reimbursement. This does not guarantee full or any reimbursement. That is the extent of assistance. No copies or duplicates will be made of past receipts. Davis Family Chiropractic does not work with or for insurance companies. We direct our time and focus on client service. We pride ourselves on customized goal-oriented nutritional and wellness programs that produce exemplary results. Davis Family Chiropractic's long-term goal is disease eradication and keeping our clients as healthy as possible throughout their life.

I have read and understood the above:

Signature _____ Date _____

Confidential Health History

Below is a list of diseases that may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of care. Check any that apply to you:

___Pain Location_____

___Numbness and tingling Location_____

___Arthritis Location_____

___Spinal or Anatomical deformity Location_____

___Skin issue Location_____

___Stomach / Intestinal issue Type_____ Medication_____

___Has inside pets ____Eats raw meats or sushi

___Traveled outside the U.S. ____History of food poisoning

___Normal bowel movements ___Daily ___Brown ___Well formed

___Lives/works around gas, oil refinery, chemicals, dyes, plastics, pesticides, machinery

___Drinks water Amount and type per day_____

___Uses microwave or plastics

___Poor sleep Sleep pattern/Hours_____

___Weight Trouble Current weight_____ Ideal weight_____

___Stress Reason_____

___Interested in health, vitamins, nutrition and improving diet

___Allergies Type_____

___Cardiovascular issue Type_____

___Stroke Year_____ Medication_____

___High Blood Pressure Medication_____

___High Cholesterol Medication_____

___Gastric Reflux / Heartburn Medication_____

___Gallbladder issue Removed when? (Age/Year)_____

___Diabetes Medication_____

___Liver issue Type_____ Medication_____

___Lung issue Type_____ Medication_____

___Kidney issue Type_____ Medication_____

___Hormonal issue Type_____ Medication_____

___Thyroid issue Type_____ Medication_____

___Bladder issue Type_____ Medication_____

___Ovary / Uterus issue Type_____ Medication_____

___Prostate / Testicle issue Type_____ Medication_____

___Autoimmune Disorder Type_____ Medication_____

___Fibromyalgia Medication_____

___Attention Deficit / Spectrum Disorders Medication_____

___Osteopenia / Osteoporosis Medication_____

___Blood Disorder Type_____ Medication_____

___Cancer Type_____ Date of Remission_____

___HIV Positive / AIDS

___Fibroids Location_____ Was surgery needed? Y N

___Endometriosis Was surgery needed? Y N

___Organ or Body Part Removed Type_____ Year_____

___Multiple infections in one year Type_____ Medication_____

___Mental Disorder Type_____ Medication_____

___Currently pregnant Trimester 1 2 3

Other unlisted ailments _____

Check all that apply to you:

Exercise	**Work Activity**	**Habits** (even if former)
□ None	□ Sitting	□ Smoking; packs/day____
□ Moderate	□ Standing	□ Alcohol; drinks/day____
□ Daily	□ Light Labor	□ Coffee/Caffeine; cups/day____
□ Heavy	□ Heavy Labor	□ Illegal Drug Use; type____

Do you drink soda or energy drinks? ___Yes ____No Drinks/week_____

Other than listed above, any other: _____

Current Medications:_____

Supplements/Nutrition:_____

Hospitalizations/Operations:_____

Fractures/Dislocations/Sprains:_____

Severe Trauma/Accident/Falls (ex. Car accident,etc.)_____

FAMILY HISTORY

Include information on brothers, sisters, parents, grandparents. **DO NOT INCLUDE YOURSELF**.

___Diabetes ___ High Blood Pressure ___ Food Allergies ___Cancer ___Alcoholism
___Thyroid/Goiter ___Heart Disease ___ Kidney Disease ___ Depression ___Obesity

CHECK ANY OF THE FOLLOWING YOU'VE HAD IN THE LAST SIX MONTHS:

Musculoskeletal

- ☐ Low Back Pain
- ☐ Pain Between Shoulder
- ☐ Neck Pain
- ☐ Arm Pain
- ☐ Joint Pain / Stiffness
- ☐ Walking Problems
- ☐ Difficulty Chewing / Clicking Jaw
- ☐ General Stiffness

General

- ☐ Fatigue
- ☐ Allergies
- ☐ Loss of Sleep
- ☐ Fever
- ☐ Headaches

Genito-Urinary

- ☐ Bladder Trouble
- ☐ Painful/Excessive Thirst
- ☐ Discolored Urine

Male

- ☐ Prostate/Sexual Dysfunction
- ☐ Other:_____

Nervous System

- ☐ Nervous
- ☐ Numbness
- ☐ Paralysis
- ☐ Dizziness
- ☐ Forgetfulness
- ☐ Confusion/Depression
- ☐ Fainting
- ☐ Convulsions
- ☐ Cold/Tingling Extremities

EENT

- ☐ Vision Problems
- ☐ Dental Problems
- ☐ Sore Throat
- ☐ Ear Aches
- ☐ Hearing Difficulties
- ☐ Stuffy Nose/Sinuses

Female

- ☐ Menstrual Irregularities
- ☐ Menstrual Cramps
- ☐ Vaginal Pain/Infection
- ☐ Breast Pain/Lumps
- ☐ Sexual Dysfunction
- ☐ Decreased Libido

When was your last period?_____

Gastrointestinal

- ☐ Poor/Excessive Appetite
- ☐ Excessive Thirst
- ☐ Frequent Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Abdominal Cramps
- ☐ Gas/Bloating After Meals
- ☐ Heartburn
- ☐Tan/Black/Bloody Stools
- ☐Colitis

CVR

- ☐ Chest Pain
- ☐ Short Breath
- ☐ Blood Pressure Problems
- ☐ Irregular Heartbeat
- ☐ Heart Problems
- ☐ Lung Problems/Congestion
- ☐ Varicose Veins
- ☐ Ankle Swelling
- ☐ Stroke

Signature:_____ Date:_____

Informed Consent to Treat

State law requires us to obtain your informed consent before starting treatment:

I,_____ , of _____ (City/State) do hereby give my consent to the performance of conservative noninvasive treatment to the joints and soft tissues. I understand that procedures may consist of manipulations/adjustments involving the movement of the joints and soft tissues. Physical therapy and exercises may also be used. I have made my decision voluntarily. Although spinal manipulation/adjustment is considered to be one of the safest, most effective forms of therapy for musculoskeletal problems, I am aware that there are other risks and possible complications associated with these procedures as follows:

Soreness / Bruising: I'm aware that I may experience soreness or bruising in the treated areas.

Fractures / joint injury: I further understand that in isolated cases underlying physical defects, deformities, or pathologies, like weak bones from osteoporosis, may render the patient susceptible to injury. When osteoporosis or other abnormalities are detected, Davis Family Chiropractic proceeds with extra caution.

Stroke: Although strokes happen with some frequency in our world, strokes from chiropractic adjustments are extremely rare. I'm aware that this serious side effect is reported to occur once in 10 million treatments. Once in 10 million is about the same chance as aspirin or Tylenol causing death. Once in 1 million are the same odds of getting hit by lightning.

Dizziness: Temporary symptoms like dizziness and nausea are also rare.

Burns: Some of the machines used in this office generate heat that may rarely cause a burn. Despite precautions, if a burn is obtained, there'll be a temporary increase in pain and possible blistering. This should be reported to the Doctor.

Reasonable alternatives to these procedures have been explained to me including rest, home applications of therapy, exercises, and possible surgery and/or education.

Medications: Medications can be used to reduce pain or inflammation. I am aware that long-term or overuse of medication is always a cause for concern. Drugs may mask pathology, produce inadequate or short-form relief, undesirable side effects, physical or psychological dependence, and may have to be continued indefinitely. Some medications may involve serious risks. At no time will Davis Family Chiropractic recommend any changes to medications. Questions about your medications need to be answered by your prescribing physician.

Rest / Exercise: bed rest is not likely to reverse pathology, although it may temporarily reduce inflammation and pain. The same is true of home therapy exercises.

Surgery: surgical risks may include unsuccessful outcomes, complications, pain, reactions to anesthesia, and prolonged recovery.

Non-treatment: I understand the potential risks of refusing or neglecting care may include increased pain, scar and adhesion formation, restricted motion, possible nerve damage, increased inflammation, and worsening of pathology. The affirmation may complicate treatment making recovery and rehabilitation more difficult and lengthy.

I have read, or have had read to me, the above explanation of chiropractic treatment. Any questions I have had regarding these procedures have been answered to my satisfaction **prior to my signing this consent form**. To attest to my consent to these procedures, I hereby affix my signature to this authorization for treatment.

Signature of patient:_____ Date/Time: _____

Signature of witness: _____

HIPAA

I consent to the use or disclosure of my protected health information by Davis Family Chiropractic for the purpose of analyzing, diagnosing, or providing treatment to me. I understand that analysis, diagnosis, or treatment of me by Davis Family Chiropractic may be conditioned upon my consent as evidenced by my signature below.

I understand I have the right to request a restriction on how my protected health information is used or disclosed to carry out treatment or healthcare operations of Davis Family Chiropractic. Davis Family Chiropractic is not required to agree to the restrictions that I may request. However, if Davis Family Chiropractic agrees to a restriction that I request, the restriction is binding on Davis Family Chiropractic. Davis Family Chiropractic will never share my health or personal information without my written consent.

I have the right to revoke this consent, in writing, at any time, except to the extent that Davis Family Chiropractic has taken action in reliance on this Consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse, will never be shared and always kept secure. This protected health information relates to my past, present or future physical and mental health or condition that identifies me, or a reasonable basis to believe the information may identify me.

Upon request, I can be provided with a copy of the Notice of Privacy Practices of Davis Family Chiropractic and understand that I have a right to review the Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment or in the performance of health care operations of Davis Family Chiropractic. The Notice of Privacy Practices also describes my rights and duties of Davis Family Chiropractic with respect to my protected health information.

24 Hr. Cancellation Policy

440-624-4214

(Please store this number in your phone)

Davis Family Chiropractic has a 24-hour cancellation/rescheduling policy. ***If you miss your appointment, cancel, or change your appointment with less than 24 hours notice, you will be charged the amount of your scheduled visit.*** This policy is in place out of respect for our therapists and our clients. Cancellations with less than 24-hour notice are difficult to fill. By giving last-minute notice or no notice at all, you prevent someone else from being able to be treated. By signing below, you acknowledge that you have read and understood the Cancellation Policy for Davis Family Chiropractic as described above.
Thank you for your understanding and cooperation.

_____ _____

Signature of Patient or Personal Representative | Printed Name of Patient

_____ _____

Date of Signing | Description of Personal Representative's Authority