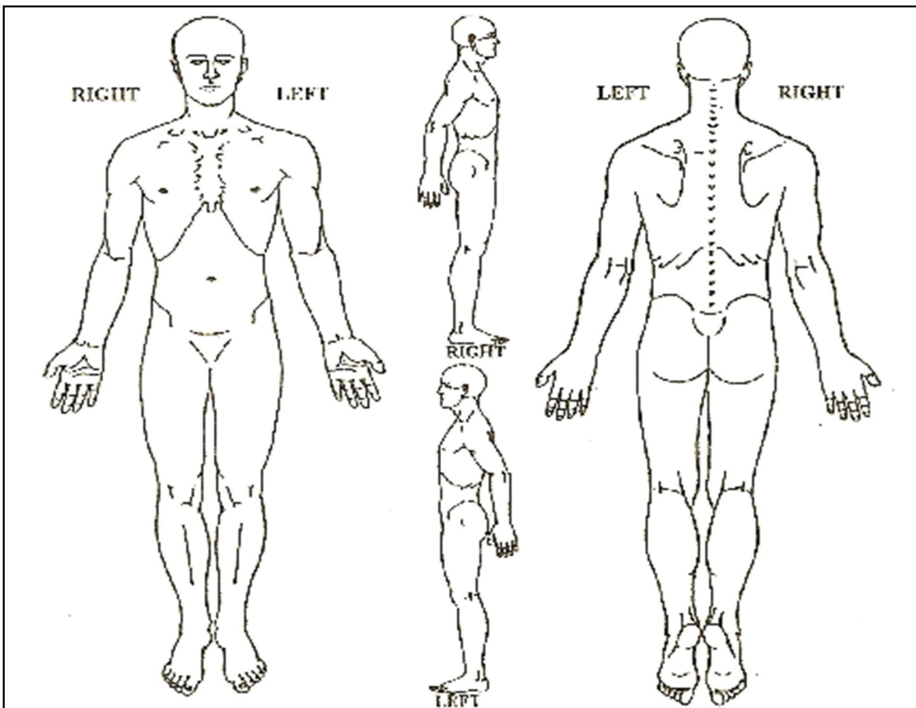
ZUKER CHIROPRACTIC CONFIDENTIAL PATIENT INFORMATION Case # ____________________

Name: (Last)_________________________ (First) ____________________ (MI) _______
Address ____________________City ____________________ State ______ Zip ________
Preferred contact phone: ____________________ Birth Date: ____/____/________ Age ______
Sex: Male Female Marital Status: M S D W Separated email address ____________________
Do we have your permission to contact you via email? Yes No
Occupation: ____________________Employer: ____________________
Emergency contact name: ____________________ Phone : ____________________
Referred by ? ____________________(Physician, Friend, Website, Google)
Chiropractors you have seen in the past: Name: ____________________ Date of last visit: ___________
Is this problem due to: Auto accident ___ Work injury ___ Other injury (fall, etc.)____ Date of Injury _______________
Was injury reported? Y N Have you missed work or school due to this? Y N Dates: ____________________
Name of Primary Care Physician ____________________ May we contact them? Y N

SYMPTOMS:
Describe your primary complaint: ____________________
Did it come on SUDDENLY or GRADUALLY? When did it start? ____________ What caused It? ____________________
Rate your Pain: (0 = Pain free, 10 = unbearable) 1 2 3 4 5 6 7 8 9 10
How many hours per day do you experience this problem? ___________
What makes it worse?____________________ Better? ____________________
Describe your symptom (pain, numb, sharp, dull, throbbing, etc?) ____________________
Doctors, PT's seen? ____________________ Other treatments tried? ____________________
Does it radiate? (arms, legs, head, etc) ____________________ Are you numb anywhere? Y N Where? __________
Any changes in bodily functions? (urination, bowel habits, sexual function, digestion, vision, other) Y N _____________
Have you had this same problem before? Y N When? ___________ Any family history of this problem? _____________
What activities does this restrict you from doing? ____________________
Percentage of normal you can perform the above activity: 0 – 25% 26 – 50% 51 – 75% 76% - 100%
Any other complaints/symptoms? ____________________



Please mark this picture with the location of your complaint(s). Also describe the problem (pain, tingling, numbness, sharp, dull) so that the doctor will have the most complete understanding of your condition, so that the best and most appropriate treatment can be provided. Thank you for your attention to detail.

Please Turn Over To Complete

General Health Information:

Height _______ Weight _______ Do you smoke? Y N Drink alcohol? Y N Play sports? Y N Exercise? Y N

What Vitamins / supplements do you take? ______________________________

What medications or drugs are you taking, and why? ______________________________

____

Do you have **any** other health problems? ______________________________

Do you have a family history of any of the following:

Diabetes Heart Kidney Cancer Back Stroke Arthritis Other ______________________________

List any recent and/or past (w/ dates):

Accidents, falls or injuries: ______________________________ Hospitalizations: ______________________________

Broken bones or dislocations: ______________________________ Spinal treatments: ______________________________

Tests performed i.e. X-Rays, ECG, MRI, CT, Bone Scan, Blood Tests, etc: ______________________________

Surgeries /operations: ______________________________

PAYMENT IS EXPECTED AT TIME OF VISIT !

My Primary insurance is: Blue Cross Blue Shield ___ Medicare___ Medicaid___ Other ______________________________

My Secondary insurance: Blue Cross Blue Shield ___ Medicare___ Medicaid___ Other ______________________________

Person responsible for payment: ______________________________

I will be paying today by: Cash _____ Check _____ Credit Card ____ Care Credit ____

***All above questions have been answered accurately, and I understand that giving incorrect information can be dangerous. I authorize this office to release any necessary information pertaining to my treatment to third party payers or to other health care providers. I authorize and request my insurance company to pay directly to this office any payable benefits. I further understand that insurance payments may be less than the actual fee for services, and I agree that I am responsible for any outstanding amount owed to this office.**

Patient/ Guardian Signature______________________________Date ______________________________

Privacy Practices Acknowledgment

I acknowledge that:

I was able to review the Zuker Chiropractic Notice of Privacy Practices and understand my rights contained in the notice.

The Notice of Privacy Practices was posted in a clear and prominent location where I was able to read the Notice of Privacy Practices.

I was able to view the Notice of Privacy Practices on the first day I received health care services after January 1, 2020.

I may request a copy of the Notice of Privacy Practices for my records.

By my signature, I provide Zuker Chiropractic with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment and health care operations as described in the Notice of Privacy Practices.

HIPPA Information Release Permission

Information about me may be released to the following individuals (please include name and contact number):

____

____

____

Patient (or Guardian's) Signature Date

____

Authorized Facility Signature Date

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:______________

Pregnancy Notice: Female Patients Only

This is to certify that to the best of my knowledge I am not pregnant, and the above doctor and associates have my permission to perform and x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual cycle: ______________ Signature: ____________________________________Date:______________