First name: _____ Middle Initial: ___ Last name: _____

Nick Name/Preferred name to be called: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Home #: (____) ____-_____ Cell #: (____) ____-_____ Cell carrier: _____

Email Address: _____

Preferred method of contact: ◯ Home ◯ Cell ◯ Email

Consent to Text Message Reminder: ◯ YES ◯ NO

SSN: ____-___-_____ Gender: _____ Birth date: ___/___/____

Marital Status: ◯ Single ◯ Married ◯ Divorced ◯ Widowed ◯ Domestic Partnership

Emergency Contact Name: _____ Number: (____) ____-_____

Emergency Contact Relationship: ◯ Spouse ◯ Domestic Partner ◯ Other: _____

Your Occupation: _____

Your Employer: _____ Work Number: (____) ____-_____

How did you find out about The Dalles Chiropractic? _____

Family Medical Doctor: _____ Number: (____) ____-_____

Do you have insurance: ◯ YES ◯ NO (complete the following; unless we have made a copy)

Insurance Carrier: _____

Insurance ID #: _____

Insurance Group #: _____

WORK RELATED INJURY: ◯ YES ◯ NO

Did you notify your employer of the accident? ◯ YES ◯ NO

AUTO ACCIDENT: ◯ YES ◯ NO

How many days have you missed from work? _____

INTERNAL USE ONLY

Staff _____

Doctor _____

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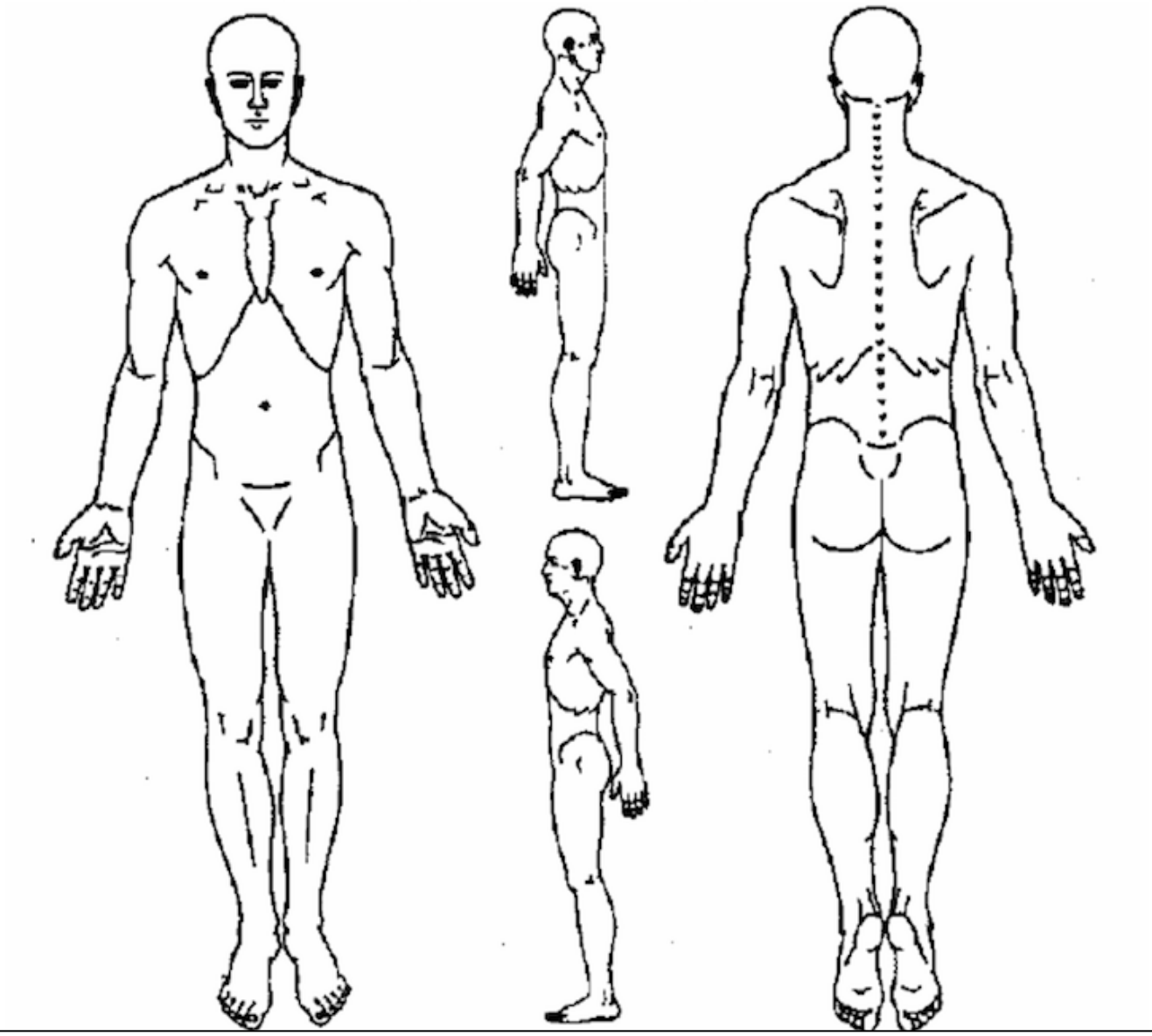
Patient Name:_____ Date:_____

Pain Diagram

Please mark the area of injury or discomfort on the chart below, using the appropriate symbols:

Numbness	Pins & Needles	Burning	Aching	Stabbing
- - - - - -	o o o o o	^ ^ ^ ^	x x x x	⊗ ⊗ ⊗ ⊗



FOR INTERNAL USE ONLY

Doctor review all areas of complaint with patient _____

Doctor notes on review_____

_____

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Circle Y if you have the following or circle Y if a family member has the following

CONDITION	SELF	FAMILY	RELATIONSHIP	DR Review	CONDITION	SELF	FAMILY	RELATIONSHIP	DR Review
Alcoholism	Y	Y			Loss of Balance	Y	Y		
Arm Pain	Y	Y			Loss of Memory	Y	Y		
Arthritis	Y	Y			Loss of Smell	Y	Y		
Asthma-Hay Fever	Y	Y			Loss of Taste	Y	Y		
Back Pain	Y	Y			Low Blood Pressure	Y	Y		
Back trouble	Y	Y			Menstrual Problems	Y	Y		
Breathing Problems	Y	Y			Muscle Spasms	Y	Y		
Broken/Fractured bones	Y	Y			Neck Pain	Y	Y		
Bursitis	Y	Y			Nervousness	Y	Y		
Cancer	Y	Y			Neuralgia	Y	Y		
Chest Pain/Tightness	Y	Y			Numbness in Fingers/Toes	Y	Y		
Circulation Problems	Y	Y			Osteoarthritis	Y	Y		
Cold Feet/Hands	Y	Y			Osteoporosis	Y	Y		
Constipation	Y	Y			Pace Maker	Y	Y		
Coughing up Blood	Y	Y			Pinched Nerve	Y	Y		
Depression	Y	Y			Plantar Fasciitis	Y	Y		
Diabetes	Y	Y			Rheumatoid Arthritis	Y	Y		
Difficulty Urinating	Y	Y			Scoliosis	Y	Y		
Disc Problems	Y	Y			Seizures/Epilepsy	Y	Y		
Dizziness	Y	Y			Shoulder Pain	Y	Y		
Drug addiction	Y	Y			Sinus Problems	Y	Y		
Ears Ringing/Buzzing	Y	Y			Sleeping Problems	Y	Y		
Eating Disorders	Y	Y			Stiff Neck	Y	Y		
Emphysema	Y	Y			Stomach Problems	Y	Y		
Epilepsy	Y	Y			Stroke	Y	Y		
Excessive Bleeding	Y	Y			Tension	Y	Y		
Fainting	Y	Y			Ulcers	Y	Y		
Fatigue	Y	Y			Unusual Bowel Patterns	Y	Y		
Fever	Y	Y			Weakness in arms/legs	Y	Y		
Frequent Colds	Y	Y			Weight loss/Gain	Y	Y		
Gall Bladder Problems	Y	Y			Liver Problems	Y	Y		
Headaches/Migraines	Y	Y			Light sensitivity	Y	Y		
Heart Disease	Y	Y			Other not Listed:	Y	Y		
Heart Problems	Y	Y							
Hepatitis A/B/C	Y	Y							
High Blood Pressure	Y	Y			Medications currently taking:				
Hip Problems	Y	Y							
HIV Positive	Y	Y							
Indigestion Problems	Y	Y			Medication Allergies:				
Insomnia	Y	Y							
Irritability	Y	Y			Other Allergies:				
Joint Pain/Swelling	Y	Y							
Kidney Problems	Y	Y							

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HISTORY OF CHIEF COMPLAINT:

Todays date: _____

Patient's Name: _____

What brings you in Today: ___ _____

Date symptoms appeared: _____

Have you ever had this same/similar condition before? If yes, when and describe:
_____
_____
_____

NOTES:_____
_____
_____
_____
_____
_____
_____
_____
_____

SOCIAL HISTORY

		DR Review			DR Review
Do you exercise?	Y/N		Do you have Family Pressures?	Y/N	
Do you have Financial Pressures?	Y/N		Do you drink alcohol?	Y/N	
Do you have High Stress Activities?	Y/N		Do you consume caffeine?	Y/N	
Do you use Tobacco?	Y/N		Do you have any other Mental stresses?	Y/N	
Do you use legal or illegal drugs?	Y/N		Other: Please Specify	Y/N	

Have you had any major illnesses? ◯ YES ◯ NO If yes, when and what? _____

_____

_____

Have you had any injuries, falls or surgeries? ◯ YES ◯ NO If yes, when and what? _____

_____

_____

When was your last physical examination? _____

How many children do you have? _____ Names and ages: _____

_____

WOMAN ONLY

How many child births? _____ Vaginal: _____ C-Section: _____

Are you currently pregnant? ◯ YES ◯ NO If yes, when is your due date: _____

INTERNAL USE ONLY:
Page reviewed with Patient
DR Initials: _____

PATIENT NAME_____PATIENT DATE OF BIRTH:_____

AUTHORIZATION AND RELEASES: (please initial)

_____ I authorize payment of insurance benefits directly to the chiropractor.

_____ I authorize The Dalles Chiropractic to release any information necessary to communicate with my personal physician and/or other healthcare providers/payers to secure the payment of benefits.

_____ I understand that I am financially responsible for all costs of chiropractic care, regardless of insurance coverage. I understand that if I am sent to collections there will be an added 40% charge to my balance to cover professional fees.

_____ I understand that if I suspend/terminate my Auto/Worker's Comp. treatment of care, as determined by my treating doctor, any fees for professional services WILL become due and payable immediately or I will be sent to collections with an added 40% charge to cover professional fees.

_____ I understand and agree to allow this chiropractic office to use my Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. My PHI is going to be used in this office and obtaining payment for services.

_____ I understand and agree that I have been given a copy of The Dalles Chiropractic's PHI information

_____ I understand as a Medicare Patient that Medicare does not cover services that are listed below and I agree that these services are optional. I understand and agree to be financially responsible for services that are not covered by my Medicare plan according to the best recommended treatment by the doctor.

Patient/Guardian Signature Authorizing Care: _____ Date:_____

MEDICARE PATIENTS

ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN)

NOTE: If Medicare doesn't pay for *any services* below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the any of the services listed below.

(D)	***(E)* Reason Medicare May Not Pay:**	***(F)* Estimated Cost: Talk with billing to find this out**
Initial Examination	Not a covered service	
Re-Exams	Not a covered service	
Intersegmental Traction Table	Not a covered service	
Any treatments to arms or legs	Not a covered service	
Electrotherapy	Not a covered service	
Exercises	Not a covered service	

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Patient Health Information Consent Form

Patient Name: _____ Date of Birth: _____

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your (PHI) we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow The Dalles Chiropractic to use your PHI for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, you agree to allow The Dalles Chiropractic to submit requested PHI to the health Insurance Company (or companies) provided to us by you for the purpose of payment. Be assured that we will limit the release of all PHI to the minimum needed for what the insurance companies require for payment on your behalf.
2. You have the right to examine and obtain a copy of your health records at any time and the right to request corrections. You may request to know what disclosures have been made and submit in writing any further restrictions on the use of your PHI. The Dalles Chiropractic is obligated to agree to those restrictions only to the extent that we coincide with the state and federal law.
3. Your written consent need only be obtained once for all subsequent care given to you here at The Dalles Chiropractic.
4. You may provide a written request to revoke consent at any time during care. This will not affect the use of your records for the care given, prior to the date of the written request that revokes consent but will apply to any care given after the request has been made. With such a request, The Dalles Chiropractic would no longer be able to bill any insurance and you will be required to pay in full for services rendered.
5. The Dalles Chiropractic may contact you periodically regarding appointments, treatments, products, services, or charitable work that is performed here. You have the right to opt-out of any marketing or fundraising communications at any time.
6. For your security and right to privacy, all staff have been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not available to those who do not need them.
7. You have the right to file a formal complaint with our privacy official and the Secretary of HHS about any possible violations of these policies and procedures without retaliation by The Dalles Chiropractic.
8. The Dalles Chiropractic, reserves the right to make changes to this notice and to make the new notice provisions effective for all PHI that it maintains. You will be provided with a new notice at you next visit following any changes.
9. This notice is effective on the date signed below.
10. If you refuse to sign this consent for the purpose of treatment, payment and health care operations, Dr. Keilman has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Patient Signature: _____ Date: _____

INFORMED CONSENT

PATIENT NAME_____PATIENT DATE OF BIRTH:_____

The primary treatment used by doctors of chiropractic is the spinal manipulation, sometimes called spinal adjustment.

- **The nature of the chiropractic adjustment.**
  I will use my hands, a mechanical instrument or a mechanical drop table upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel or sense movement.

- **The material risks inherent in chiropractic adjustment.**
  As with any healthcare procedure, there are certain complications, which may arise during chiropractic manipulation. Those complications include: fractures, disc injuries, dislocations, muscle strain, Horner's syndrome, diaphragmatic paralysis, cervical myelopathy and 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 treatment.

- **The probability of those risks occurring.**
  Fractures are rare occurrences and generally result from some underlying weakness of the bone, which we check for during the taking of your history and during examination. Stroke has been the subject of tremendous disagreement within and without the profession with one prominent authority saying that there is at most a one-in-a-million chance of such an outcome. Since even that risk should be avoided if possible, we employ tests in our examination which are designed to identify if you may be susceptible to that kind of injury. The other complications are also generally described as "rare."
- **Ancillary treatment.**
  In addition to chiropractic adjustments, I may use the following treatments:
  Intersegmental Traction Table
  We use a Haberer table to promote and preserve mobility of movement of the vertebrae throughout the spine and to help the muscles relax. The code used for this service is 97012 and patients are on this table for 10-15 minutes per treatment.

  These treatments involve the following additional significant risks:
  Soreness, bruising (unlikely), possible nausea and dizziness

- **The availability and nature of other treatment options.**
  Other treatment options for your condition include:

  - Self-administered, over-the-counter analgesics and rest
  - Medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers.
  - Hospitalization with traction
  - Surgery

- **The material risks inherent in such options and the probability of such risks occurring include:**

  - Overuse of over-the-counter medications produces undesirable side effects. If complete rest is impractical, premature return to work and household chores may aggravate the condition and extend the recovery time. The probability of such complications arising is dependent upon the patient's general health, severity of the patient's discomfort, his pain tolerance and self-discipline in not abusing the medicine. Professional literature describes highly undesirable effects from long term use of over-the-counter medicines.

PATIENT NAME_____PATIENT DATE OF BIRTH:_____

- Prescription muscle relaxants and painkillers can produce undesirable side effects and patient dependence. The risk of such complications arising is dependent upon the patient's general health, severity of the patient's discomfort, his pain tolerance, self-discipline in not abusing the medicine and proper professional supervision. Such medications generally entail very significant risks - some with rather high probabilities.

- Hospitalization in conjunction with other care bears the additional risk of exposure to communicable disease, iatrogenic (doctor induced) mishap and expense. The probability of iatrogenic mishap is remote, expense is certain, exposure to communicable disease is likely with adverse result from such exposure dependent upon unknown variables.

- The risks inherent in surgery include adverse reaction to anesthesia, iatrogenic (doctor induced) mis- hap, all those of hospitalization and an extended convalescent period. The probability of those risks occurring varies according to many factors.

- **The risks and dangers attendant to remaining untreated.**
  Remaining untreated allows the formation of adhesions and reduces mobility which sets up a pain reaction further reducing mobility. Over time, this process may complicate treatment making it more difficult to treat and less effective the longer it is postponed. The probability that non-treatment will complicate a later rehabilitation is very high.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.

I have read or have had read to me the above explanation of the chiropractic adjustment and related treatment.

Date: _____ Patient's Printed Name: _____

Patient Signature: _____

Parent/Guardian Signature: _____

Chiropractic Assistant Witness Signature: _____

I have had the opportunity to discuss this Informed consent with Dr. Gregory Keilman and have had my questions answered to my satisfaction.

Date: _____ Patient Signature: _____

Doctor Signature: _____

By signing below, I state that I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Date: _____ Patient Signature: _____