evergreen
chiropractic

PATIENT INFORMATION

Last Name _____ First Name _____ Middle Initial _____ Birthdate _____/_____/_____

Address _____ City _____ State_____ Zip _____

Biological Sex ❑ Male ❑ Female Preferred Pronoun ❑ he/him/his ❑she/her/hers ❑ they/them/theirs

❑ Married ❑ Widowed ❑ Single ❑ Minor ❑ Separated ❑ Divorced ❑ Partnered for _____ years

Phone Number (cell) _____ (home) _____ Email _____

Occupation _____ Employer/School _____ Employer/School Phone _____

IN CASE OF EMERGENCY, CONTACT Name _____ Relationship to Patient _____

Home Phone (_____) _____ Work Phone (_____) _____

Spouse's Name _____ Spouse's Phone Number (_____) _____

Who is your primary care physician? _____ Phone Number (_____) _____

Whom may we thank for referring to our office? _____

INSURANCE INFORMATION

Who is responsible for this account? _____

Relationship to Patient _____ Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ❑ Yes ❑ No

Subscriber's Name _____ Birthdate _____/_____/_____ SS# _____

Relationship to Patient _____ Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to
Name of Insurance Company(ies)
Dr. _____ all insurance benefits, if any, otherwise, payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

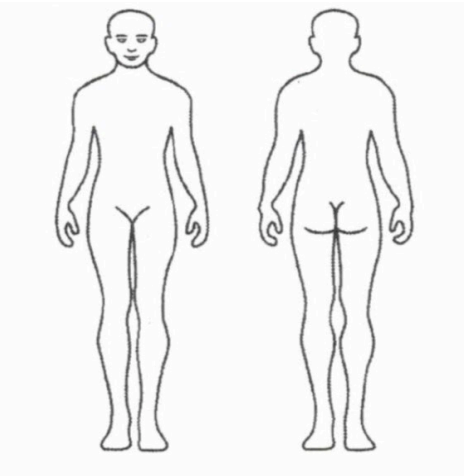
_____ _____

Signature of Patient, Parent, Guardian or Personal Representative *Please print name of Patient, Parent, Guardian, or Personal Representative*

SPECIFIC AREAS OF CURRENT COMPLAINT(S)

INSTRUCTIONS: Please only include *ONE Body Part/Area of Complaint* for Each Section Below. If there are currently multiple chief complaints please separate them from most severe to least and use the additional pages provided.

1. Body Part / Area of Complaint ❑ Neck Pain ❑ Upper Back Pain ❑Mid Back Pain ❑Low Back Pain
❑ Shoulder Pain ❑ Arm/Elbow Pain ❑ Wrist Pain ❑ Hip Pain
❑ Knee Pain ❑ Ankle Pain



Mark an X on the picture where you are experiencing pain/symptoms.

When did the pain/symptoms first begin? _____

Did the pain/symptoms begin ❑ Gradually ❑ Suddenly

How did the pain/symptoms begin? _____

Are the symptoms/pain getting progressively worse? ❑ Yes ❑ No

How often do you currently experience these symptoms?

❑ **Constant** 100% ❑ **Frequent** 75% ❑ **Intermittent** 50%

❑ **Occasional** 25% ❑ **Rare** 10% ❑ **Other** _____ %

Please rate the intensity of your symptoms below (0 being no pain, 10 being worst pain imaginable – Circle)

0 1 2 3 4 5 6 7 8 9 10

Activities that make the pain/symptoms increase? (Circle all that apply)

Any movement, bending neck forward, bending neck backwards, titling head to the left, tilting head to the right, turning head to the left, turning head to the right, bending forward at the waist, bending backward at the waist, titling left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, getting up from sitting position, standing, lifting, driving, walking, running, lying down, desk work, other (please describe) _____

_____

Activities that make the pain/symptoms decrease? (Circle all that apply)

Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing.

Other (please describe) _____

How would you describe your pain?

❑ **Sharp** ❑ **Dull** ❑ **Achy** ❑ **Burning** ❑ **Throbbing** ❑ **Piercing** ❑ **Stabbing** ❑ **Deep Nagging** ❑ **Shooting**

❑ **Stinging** ❑ **Other** (please describe) _____

Does the pain radiate to another part of your body? ❑ Yes ❑ No

If the pain does radiates, where does it radiate? _____

Is the pain worse at certain times of the day or night? (Circle)

Morning Afternoon Evening Night Unaffected by time of day

Does your pain/symptoms interfere with your ❑ Work ❑ Sleep ❑ Daily Routine/Activities ❑ Other _____

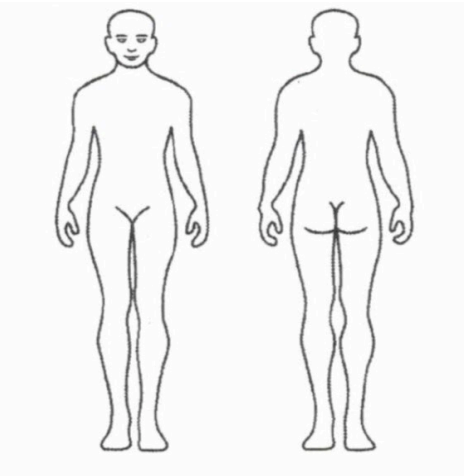
If so, please describe what activities/tasks are effected _____

_____

SPECIFIC AREAS OF CURRENT COMPLAINT(S) – Continued

INSTRUCTIONS: Please only include *ONE Body Part/Area of Complaint* for Each Section Below. If there are currently multiple chief complaints please separate them from most severe to least.

2. Body Part / Area of Complaint ❑ Neck Pain ❑ Upper Back Pain ❑Mid Back Pain ❑Low Back Pain
❑ Shoulder Pain ❑ Arm/Elbow Pain ❑ Wrist Pain ❑ Hip Pain
❑ Knee Pain ❑ Ankle Pain



Mark an X on the picture where you are experiencing pain/symptoms.

When did the pain/symptoms begin _____

Did the pain/symptoms begin ❑ Gradually ❑ Suddenly

How did the pain/symptoms begin _____

Are the symptoms/pain getting progressively worse? ❑ Yes ❑ No

How often do you currently experience these symptoms?

❑ **Constant** 100% ❑ **Frequent** 75% ❑ **Intermittent** 50%

❑ **Occasional** 25% ❑ **Rare** 10% ❑ **Other** _____ %

Please rate the intensity of your symptoms below (0 being no pain, 10 being worst pain imaginable – Circle)

0 1 2 3 4 5 6 7 8 9 10

Activities that make the pain/symptoms increase? (Circle all that apply)

Any movement, bending neck forward, bending neck backwards, titling head to the left, tilting head to the right, turning head to the left, turning head to the right, bending forward at the waist, bending backward at the waist, titling left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, getting up from sitting position, standing, lifting, driving, walking, running, lying down, desk work, other (please describe) _____

_____

Activities that make the pain/symptoms decrease? (Circle all that apply)

Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing.

Other (please describe) _____

How would you describe your pain?

❑ **Sharp** ❑ **Dull** ❑ **Achy** ❑ **Burning** ❑ **Throbbing** ❑ **Piercing** ❑ **Stabbing** ❑ **Deep Nagging** ❑ **Shooting**

❑ **Stinging** ❑ **Other** (please describe) _____

Does the pain radiate to another part of your body? ❑ Yes ❑ No

If the pain does radiates, where does it radiate? _____

Is the pain worse at certain times of the day or night? (Circle)

Morning Afternoon Evening Night Unaffected by time of day

Does your pain/symptoms interfere with your ❑ Work ❑ Sleep ❑ Daily Routine/Activities ❑ Other _____

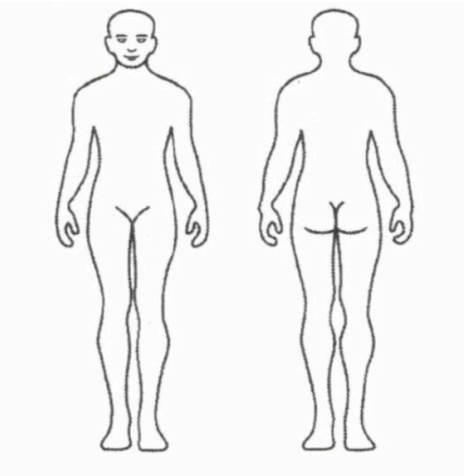
If so, please describe what activities/tasks are effected _____

_____

SPECIFIC AREAS OF CURRENT COMPLAINT(S) – Continued

INSTRUCTIONS: Please only include *ONE Body Part/Area of Complaint* for Each Section Below. If there are currently multiple chief complaints please separate them from most severe to least.

3. Body Part / Area of Complaint ❑ Neck Pain ❑ Upper Back Pain ❑Mid Back Pain ❑Low Back Pain ❑ Shoulder Pain ❑ Arm/Elbow Pain ❑ Wrist Pain ❑ Hip Pain ❑ Knee Pain ❑ Ankle Pain



Mark an X on the picture where you are experiencing pain/symptoms.

When did the pain/symptoms begin _____

Did the pain/symptoms begin ❑ Gradually ❑ Suddenly

How did the pain/symptoms begin _____

Are the symptoms/pain getting progressively worse? ❑ Yes ❑ No

How often do you currently experience these symptoms?

❑ **Constant** 100% ❑ **Frequent** 75% ❑ **Intermittent** 50%

❑ **Occasional** 25% ❑ **Rare** 10% ❑ **Other** _____ %

Please rate the intensity of your symptoms below (0 being no pain, 10 being worst pain imaginable – Circle)

0 1 2 3 4 5 6 7 8 9 10

Activities that make the pain/symptoms increase? (Circle all that apply)

Any movement, bending neck forward, bending neck backwards, titling head to the left, tilting head to the right, turning head to the left, turning head to the right, bending forward at the waist, bending backward at the waist, titling left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, getting up from sitting position, standing, lifting, driving, walking, running, lying down, desk work, other (please describe) _____

_____

Activities that make the pain/symptoms decrease? (Circle all that apply)

Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing.

Other (please describe) _____

How would you describe your pain?

❑ **Sharp** ❑ **Dull** ❑ **Achy** ❑ **Burning** ❑ **Throbbing** ❑ **Piercing** ❑ **Stabbing** ❑ **Deep Nagging** ❑ **Shooting**

❑ **Stinging** ❑ **Other** (please describe) _____

Does the pain radiate to another part of your body? ❑ Yes ❑ No

If the pain does radiate, where does it radiate? _____

Is the pain worse at certain times of the day or night? (Circle)

Morning Afternoon Evening Night Unaffected by time of day

Does your pain/symptoms interfere with your ❑ Work ❑ Sleep ❑ Daily Routine/Activities ❑ Other _____

If so, please describe what activities/tasks are effected _____

_____

PAST HEALTH HISTORY

What treatment have you already received for your condition(s) ❑ Medications ❑ Surgery ❑ Physical Therapy
❑ Chiropractic Services ❑ None ❑ Other _____

Name and Address of other doctor(s) who have treated you for your condition(s) _____

_____

Date of Last: Physical Exam _____ Spinal X-Ray _____ Blood Test _____
Spinal Exam _____ Chest X-Ray _____ Urine Test _____
Dental X-Ray _____ MRI, CT-Scan, Bone Scan _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	❑ Yes	❑ No	Chicken Pox	❑ Yes	❑ No	Liver Disease	❑ Yes	❑ No	Rh. Arthritis	❑ Yes	❑ No
Alcoholism	❑ Yes	❑ No	Diabetes	❑ Yes	❑ No	Measles	❑ Yes	❑ No	Rheum. Fever	❑ Yes	❑ No
Allergy Shots	❑ Yes	❑ No	Emphysema	❑ Yes	❑ No	Migraines	❑ Yes	❑ No	Scarlet Fever	❑ Yes	❑ No
Anemia	❑ Yes	❑ No	Epilepsy	❑ Yes	❑ No	Miscarriage	❑ Yes	❑ No	Stroke	❑ Yes	❑ No
Anorexia	❑ Yes	❑ No	Fractures	❑ Yes	❑ No	Mononucleosis	❑ Yes	❑ No	Thyroid Prob.	❑ Yes	❑ No
Appendicitis	❑ Yes	❑ No	Glaucoma	❑ Yes	❑ No	Multiple Sclerosis	❑ Yes	❑ No	Tonsillitis	❑ Yes	❑ No
Arthritis	❑ Yes	❑ No	Goiter	❑ Yes	❑ No	Mumps	❑ Yes	❑ No	Tuberculosis	❑ Yes	❑ No
Asthma	❑ Yes	❑ No	Gonorrhea	❑ Yes	❑ No	Osteoporosis	❑ Yes	❑ No	Tumors	❑ Yes	❑ No
Bleeding Disorder	❑ Yes	❑ No	Gout	❑ Yes	❑ No	Pacemaker	❑ Yes	❑ No	Ulcers	❑ Yes	❑ No
Breast Lump	❑ Yes	❑ No	Heart Disease	❑ Yes	❑ No	Parkinson's Disease	❑ Yes	❑ No			
Bronchitis	❑ Yes	❑ No	Hepatitis	❑ Yes	❑ No	Pinched Nerve	❑ Yes	❑ No	Other	_____	
Bulimia	❑ Yes	❑ No	Hernia	❑ Yes	❑ No	Pneumonia	❑ Yes	❑ No		_____	
Cancer	❑ Yes	❑ No	Herniated Disc	❑ Yes	❑ No	Polio	❑ Yes	❑ No		_____	
Cataracts	❑ Yes	❑ No	Herpes	❑ Yes	❑ No	Prostate Problem	❑ Yes	❑ No		_____	
Chemical			High Cholesterol	❑ Yes	❑ No	Prosthesis	❑ Yes	❑ No		_____	
Dependency	❑ Yes	❑ No	Kidney Disease	❑ Yes	❑ No	Psychiatric Care	❑ Yes	❑ No		_____	

EXERCISE
❑ None
❑ Daily
❑ Moderate
❑ Heavy

WORK ACTIVITY
❑ Sitting
❑ Standing
❑ Light Labor
❑ Heavy Labor

LIFESTYLE HABITS
❑ Smoking Packs/Day_____
❑ Alcohol Drinks/Weekly _____
❑ Coffee/Caffeine Cups/Daily _____
❑ High Stress Reason _____

Are you currently pregnant? ❑ Yes ❑ No If yes, what is your expected due date _____

Previous Trauma	Description	Date
Falls/MVA/Injuries	_____	_____
Head Injuries	_____	_____
Broken Bones/Dislocations	_____	_____
Surgeries	_____	_____

PAST HEALTH HISTORY – Continued

Are you currently taking any **MEDICATIONS**? If so, please list name, frequency and dosage.

_____

_____

_____

Pharmacy Name _____ Pharmacy Phone (if known) _____

Do you have any known **ALLERGIES**?

_____

_____

_____

Are you currently taking any **VITAMINS/HERBS/MINERALS**?

_____

_____

_____

I hereby certify that the statements and answers given on this form are accurate to the best of knowledge and understand it is my responsibility to inform this office of any changes in my health. I agree to allow this office to examine me for further evaluation.

_____ _____

Patient Signature Date

Evergreen Chiropractic Office Policies

APPOINTMENTS: Your appointments are times reserved and committed exclusively for you. We realize that emergencies do occur, and appointments must sometimes be changed. If a situation does occur, and you are unable to make your scheduled appointment, please call our office so that we can reschedule or cancel your appointment. Please note, cancelled or missed appointments without at least 2 hours advance notice may result in charges to your account. Charges made to the account will amount to $25.00 per appointment missed.

PAYMENTS: Payment is due at the time services are rendered, unless other arrangements have been made in advance. We currently accept cash, check, or VISA/MC/Discover. Returned checks are subject to $30.00 service charge. Any account that becomes delinquent will be subject to collections service. Should our clinic receive information that your insurance will no longer be covering services, such as in the incidence of maximum insurance payout met, you will be charged the applicable discounted cash rates that are due at time of service. Receipts are supplied if needed.

INSURANCE: We must emphasize that as chiropractic providers, our primary relationship is with you. As service to our patients, we do accept assignment of insurance benefits on most policies. In addition, we are participating providers with several insurance carriers and payers. You are still responsible for payment of your co-pay at the time of service. If your deductible has not been met, you are also responsible for full payment until it has been met; then, only your portion thereafter. Please note we are also happy to assist you in verifying chiropractic benefits of your particular policy.

PRIVACY POLICY: Our practice is dedicated to maintaining the privacy of your individual identifiable health information (IIHI). In conducting our business, we will create records regarding you and the treatment and service we provide you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices we maintain in our practice concerning your IIHI. By federal and state law, we must follow the terms of the notice of privacy practices we have in effect at the time.

I have received a copy of Evergreen Chiropractic, PC Privacy Policies and understand that my IIHI will be kept confidential according to the HIPPA mandates.

BENEFITS, RISKS, AND ALTERNATIVES: I understand that, as with all forms of manual therapy, there are certain benefits, risks, and alternatives to receiving chiropractic care. I accept these benefits, risks, and alternatives and understand that if I have concerns or questions regarding benefits, risks, and alternatives of Chiropractic Manipulative Therapy, I have the right to discuss them with the doctor and refuse care.

I have read and understand the above information

Signature: _____ Date: _____

- THIS PAGE IS INTENTIONALLY BLANK -

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 to not 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 involves an abnormal change in the wall of an artery that may cause a development/dislodge of a thrombus (clot) with the potential to lead to a stroke. This occurs 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. As chiropractic can involve manually and/or mechanically adjusting the cervical spine, it has been reported that chiropractic care may be a correlative risk for developing this type of stroke. The association with stroke is exceedingly rare and it is estimated to occur in approximately one in one million to one in two million cervical adjustments.

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 recommendations 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: _____

Also SIGN the ARBITRATION AGREEMENT on REVERSE side

ARBITRATION AGREEMENT

Article 1: Agreement to arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by state and federal law, and not by a lawsuit or resort to court process, except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration. Further, the parties will not have the right to participate as a member of any class of claimants, and there shall be no authority for any dispute to be decided on a class action basis. An arbitration can only decide a dispute between the parties and may not consolidate or join the claims of other persons who have similar claims.

Article 2: All Claims Must be Arbitrated: It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, as to whether this agreement is unconscionable, and any procedural disputes, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the health care provider, including any heirs or past, present, or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence-giving rise to any claim. This agreement is intended to bind the patient and the health care provider and/or other licensed health care providers, preceptors, or interns who now or in the future treat the patient while employed by, working, or associated with or serving as a back-up for the health care provider, including those working at the health care provider's clinic or office or any other clinic or office whether signatories to this form or not. All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the health care provider, and/or the health care provider's associates, association, corporation, partnership, employees, agents, and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages. This agreement is intended to create an open book account unless and until revoked.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days, and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party for such party's own benefit. Each party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court of action, upon such intervention and joinder, any existing court action against such additional personal or entity shall be stayed pending arbitration. The parties agree that provisions of state and federal law, where applicable, establishing the right to introduce evidence of any amount payable as a benefit to the patient to the maximum extent permitted by law, limiting the right to recover non-economic losses, and the right to have a judgment for future damages conformed to periodic payments, shall apply to disputes within this Arbitration Agreement. The parties further agree that the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement.

Article 4: General Provision: All claims based upon the same incident, transaction, or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statue of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with procedures prescribed herein with reasonable diligence.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the health care provider within 30 days of signature and, if not revoked, will govern all professional services received by that patient and all other disputes between the parties.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment), patient should initial here _____. Effective as of the date of first professional services.

If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this Arbitration Agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

PATIENT SIGNATURE **X** _____ DATE _____
(Or Patient Representative)

OFFICE SIGNATURE **X** _____ DATE _____

evergreen
chiropractic

May we send you appointment reminder text messages? ❑ YES ❑ NO

May we leave voice messages? ❑ YES ❑ NO

Cell Phone # _____ Provider (Verizon, AT&T, etc.) _____

I hereby give Evergreen Chiropractic PC, permission to send me text message appointment reminders and/or voice messages at the number I have provided above.

Signature _____ Date _____