Huffer Chiropractic

CONFIDENTIAL PATIENT INFORMATION

Name _____ Date of Birth ___/___/___ ☐ Male ☐ Female

Email Address _____ Phone _____ Social Security # _____

Address _____ City, State _____ Zipcode _____

Marital Status _____ # of Children _____ Occupation _____

Emergency contact _____ Emergency relation _____ Phone _____

**Please answer the questions below.

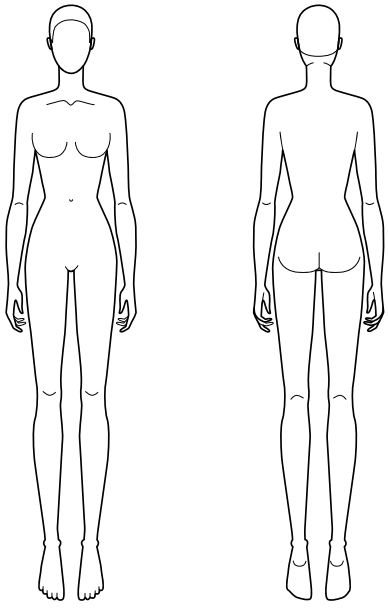
Who can we thank for referring you to Huffer Chiropractic? _____

Have you received chiropractic care before? ☐ Yes ☐ No

If yes, date of last adjustment and name of chiropractor _____

REASON FOR SEEKING CARE

Please mark all areas of concern:



Present Complaints

1. _____ How long has this been an issue? _____

Quality of discomfort: aching dull sharp stabbing stiffness tightness numb/tingling

Frequency of discomfort: constant occasional worse in the morning worse in the evening

Discomfort is: mild moderate severe / staying the same getting worse

Discomfort travels to: _____

2. _____ How long has this been an issue? _____

Quality of discomfort: aching dull sharp stabbing stiffness tightness numb/tingling

Frequency of discomfort: constant occasional worse in the morning worse in the evening

Discomfort is: mild moderate severe / staying the same getting worse

Discomfort travels to: _____

What have you done for this up until now? _____

Are you pregnant? ☐ Yes ☐ No If yes, how far along & due date _____

Known allergies: ☐ I have no know allergies to medications

List of current medications (if more than 6, please provide list to front desk) ☐ No medications

Rate your stress/anxiety levels over the past 90 days, 1-10 (10 being high stress/anxiety):

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Rate your sleep level over the past 90 days, 1-10 (10 being extremely poor sleep):

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

GENERAL HEALTH HISTORY

Past	Present		Past	Present		Past	Present	
☐	☐	Headaches	☐	☐	Ear Problems	☐	☐	Alcohol Use
☐	☐	Migraines	☐	☐	Sleeping Problems	☐	☐	High or Low Blood Pressure
☐	☐	Shortness of breath	☐	☐	Vision Problems	☐	☐	High Cholesterol
☐	☐	Allergies/ Asthma	☐	☐	Thyroid problems	☐	☐	TMJ
☐	☐	Medication side effects	☐	☐	Liver Disease	☐	☐	Digestive Problems
☐	☐	Diabetes	☐	☐	Kidney Problems	☐	☐	Pain All Over
☐	☐	Hands of feet cold	☐	☐	Light Bothers Eyes	☐	☐	Easy Bruising
☐	☐	Muscle aches	☐	☐	Urinary Problems	☐	☐	Fibromyalgia
☐	☐	Trouble walking	☐	☐	Tobacco Use	☐	☐	HIV Positive
☐	☐	Leg/foot numbness	☐	☐	Dental Problems	☐	☐	Chest Pain
☐	☐	Fainting	☐	☐	Blood Thinner Use	☐	☐	Stroke History
☐	☐	Gallbladder trouble	☐	☐	Cancer	☐	☐	Heart Pacemaker
☐	☐	Ringing in Ears	☐	☐	Depression	☐	☐	Heart Problems
☐	☐	Tension/Irritability	☐	☐	Other: _____			

PAST HISTORY

List any past auto collisions: _____ Was any care received? _____

List any past work injuries: _____ Was any care received? _____

List any past sport, recreational, or home injuries: _____

List any previous hospitalizations and surgeries: _____

FAMILY HISTORY

Father's side: ☐ Heart disease ☐ Cancer ☐ Diabetes ☐ Heavy Medication use ☐ Arthritis ☐ Other: _____

Mother's side: ☐ Heart disease ☐ Cancer ☐ Diabetes ☐ Heavy Medication use ☐ Arthritis ☐ Other: _____

Is there any other family history you want us to know about? _____

WHAT ARE YOUR PRIMARY HEATH GOALS?

1.

2.

3.

INFORMED CONSENT

To the patient (or the patient named below, whom I am legally responsible for) : Please read this entire form thoroughly before signing and dating. If you are unclear or have any questions about this form and its content, please ask immediately.

Chiropractic Adjustments:

The primary method of care provided by Huffer Chiropractic is known as chiropractic adjustments. These are highly specific intentional movements of subluxated vertebrae throughout the spinal column and bones of extremities found to cause neurological interference. These adjustments help to optimize health by facilitating neurological and biomechanical integrity, which allows maximum expression of the body's innate recuperative abilities.

Analysis/ Examination/ Treatment:

A complete case history will be performed allowing the Dr. to generate the most specific diagnosis and care plan for you. A thorough physical examination will be performed which may include vital signs, postural analysis, palpation, EMG, range of motion, muscle testing, orthopedic and neurological tests. The use of X-ray imaging may be used to determine underlying risk factors that cannot be accurately assessed during the physical examination process. Treatments may also include soft tissue and muscular therapies. Mechanical traction, neuromuscular rehabilitation techniques, nutritional, dietary and exercise counseling along with recommended homecare may also be utilized. Additional referrals to proper healthcare professionals for co-management of your case may be made.

Potential Benefits of Chiropractic Care:

The vast majority of chiropractic patients tend to achieve good to excellent improvement in their physical conditions and overall level of wellness. Regular chiropractic care can decrease symptoms of neuromusculoskeletal pain, headaches, stiffness, progression of degenerative conditions and many more. Chiropractic care can improve joint function, range of motion, flexibility, strength, posture, athletic performance and a wide array of other benefits that are all achieved through natural care. Each patient's case is unique and not all patients benefit from care equally. No guarantees are made that any specific condition, symptom or health concern may respond to chiropractic care.

Material Risks Inherent with Chiropractic Care:

As with any healthcare procedure, there are certain complications that may arise when chiropractic adjustments and other care procedures are performed. These complications include but are not limited to: fractures, muscle strain, ligamentous sprains, stroke and radiation exposure. Some patients will experience normal discomfort and soreness following initial treatments. Every reasonable effort will be made during your examination to screen for contraindications for care; however, if you have a condition that would otherwise not come to the attention of the Dr., it is your responsibility to inform.

Probability of Risks Occurring:

Fractures are rare occurrences and are generally a result from underlying weakness of the bone as in patients with osteoporosis. Your case history, examination and X-rays will be utilized to help eliminate the possible risk for fracture. Incidences of stroke are exceedingly rare. The general population has a stroke occurrence of 1 in 133,000 (not related to chiropractic care). An occurrence with chiropractic cervical adjustments is between one and one million and one in five million. Further complications listed are described as rare.

Risks of not Obtaining Chiropractic Care:

• Prolonged, reoccurring pain, discomfort and symptoms
• Reduced/limited mobility and flexibility
• Degenerative spinal conditions such as Degenerative Disc or Joint Disease
• Scar tissue deposition & adhesions
• Delayed and reduced healing response if care is postponed
• More costly and timely care of worsened conditions

Alternative Treatment to Chiropractic Care:

Other treatment options for your condition may include:
• Rest
• Self administered OTC analgesics
• Physical Therapy
• Hospitalization
• Surgery
• Medical care & prescription drugs such as anti-inflammatories, muscle relaxants, pain-killers and needle injection

SOCIAL MEDIA & TEXT REMINDERS

I consent to having my pictures posted on social media if office photos are ever taken:
Initial: _____

I consent to receiving text reminders for my appointments:
Initial: _____

CONSENT FOR CARE

- **I authorize the doctor or his staff to render care as deemed appropriate for me and / or my child.**
- **I authorize Huffer Chiropractic to release and / or request records to or from other providers as may be necessary.**
- **I understand I am responsible for all bills incurred in this office.**
- **Person responsible for this account if other than the patient?_____**
- **I understand that after any initial promotional services all care is rendered at usual and customary fees.**
- **Understand that your health information is protected by the Health Insurance Portability and Accountability Act of 1996. If you have any questions, please talk to the front desk.**
- **For my balance my preferred payment method is: ❑ Cash ❑ Check ❑ Credit Card**

Print Name _____ **Signature** _____

Date _____

You have made a great decision to get care here!

Our goal is to be your family chiropractor for life!