# Welcome to Chiropractic First, LLC

**Patient Information**

Date_____

Patient:_____
Address:_____
City:_____State:_____Zip:_____
Sex: □M □F Age: _____ DOB:_____
□Single □Married □Widowed □Separated □Divorced
Patient SS#:_____
Occupation:_____
Employer:_____
Employer Address:_____
Employer Phone:_____
Spouse's Name:_____
DOB:_____SS#:_____
Occupation:_____
Spouses Employer:_____
Whom may we thank for referring you?_____
_____

**Adult Patient Intake Form**

Insurance Co:_____
Id #:_____
Group #_____
Subscribers Name:_____
DOB:_____SS#_____

ASSIGNMENT AND RELEASE

I, the undersigned Certify that I (or my defendant) have insurance coverage with_____and assign directly to Chiropractic First, LLC. 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 hereby authorize the doctor to release all information necessary to secure the payment of benefits. I I authorize the use of this signature on all insurance submissions.

_____
Responsible Party Signature

_____
Relationship Date

**Phone Number**

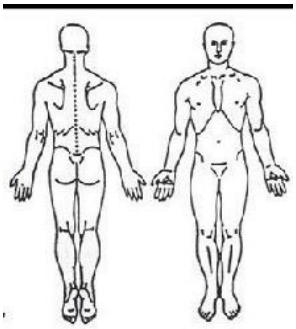
Home:_____Work:_____Ext:_____
Best time and place to reach you:_____
IN CASE OF EMERGENCY, CONTACT:
Name:_____Relationship:_____
Home Phone:_____
Work Phone:_____Ext:_____

**Accident Information**

Is this condition due to an accident? Y N Date___
Type of accident □Auto □Work □Home □Other
To whom have you made a report of accident?
□Auto Ins. □Employer □Worker Comp. □Other
Attorney Name (If applicable):_____
_____
Lein Signature:_____
Staff Initials and Date

**Patient Condition**

Reason for visit:_____
When did your symptoms begin?_____
Is this condition getting progressively worse? □Yes □No Unknown
Mark an X on the picture where you continue to have pain, numbness, or tingling.
Take the severity of your pain on a scale from 1-10 (1 being least pain..)_____
Type of pain: □ Sharp □Dull □Throbbing □Numbness □Aching □Shooting □Burning
□Tingling □Cramps □Stiffness □Swelling □Other (mark all that apply)
How often do you have this pain?_____
Is it constant or does it come and go?_____
Does it interfere with your: □Work Sleep □Daily Routine □Recreation
Activities or movements that are painful to perform: □Sitting □Standing □Walking □Bending □Lying Down



Chiropractic First, LLC
10301 Glacier Hwy, Suite 120
Juneau, AK 99801
(907)463-3051

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## Health History

What treatment have you already received for your condition? □Medications □Surgery
□Physical Therapy □Chiropractic Services □None □Other_____
Name and address of other doctor(s) who have treated you for your condition_____
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_____
Family Doctor:_____ Phone:_____ Last Seen:_____
Place a mark on "Yes" or "No" to indicate if you have had any of the following:

| | | | | | |
|---|---|---|---|---|---|
| AIDS/HIV | □Yes□No | Epilepsy | □Yes□No | Mononucleosis | □Yes□No |
| Alcoholism | □Yes□No | Fractures | □Yes□No | Multiple Sclerosis | □Yes□No |
| Allergy Shots | □Yes□No | Glaucoma | □Yes□No | Mumps | □Yes□No |
| Anorexia | □Yes□No | Goiter | □Yes□No | Gonorrhea | □Yes□No |
| Tonsillitis | □Yes□No | Anemia | □Yes□No | Appendicitis | □Yes□No |
| Osteoporosis | □Yes□No | Tuberculosis | □Yes□No | Tumors/Growths | □Yes□No |
| Gout | □Yes□No | Pacemaker | □Yes□No | Parkinson's Disease | □Yes□No |
| Arthritis | □Yes□No | Heart Disease | □Yes□No | Vaginal Infections | □Yes□No |
| Typhoid Fever | □Yes□No | Asthma | □Yes□No | Pinched Nerve | □Yes□No |
| Hepatitis | □Yes□No | Ulcers | □Yes□No | Breast Lump | □Yes□No |
| Bleeding Disorders | □Yes□No | Hernia | □Yes□No | Venereal Diseases | □Yes□No |
| | | Herniated Disc | □Yes□No | Polio | □Yes□No |
| Herpes | □Yes□No | Pneumonia | □Yes□No | Prostate | □Yes□No |
| Bronchitis | □Yes□No | High Cholesterol | □Yes□No | Kidney Disease | □Yes□No |
| Bulimia | □Yes□No | Cancer | □Yes□No | Liver Disease | □Yes□No |
| Whooping Cough | □Yes□No | Cataracts | □Yes□No | Chicken Pox | □Yes□No |
| Psychiatric Care | □Yes□No | Chemical Dependency | □Yes□No | Diabetes | □Yes□No |
| Rheumatic Fever | □Yes□No | Measles | □Yes□No | Emphysema | □Yes□No |
| Migraine | □Yes□No | Scarlet Fever | □Yes□No | Other:_____ | |
| Headaches | □Yes□No | Stroke | □Yes□No | | |
| Miscarriage | □Yes□No | Suicide Attempt | □Yes□No | | |

**Exercise**
□None
□Moderate
□Daily
□Heavy
Type_____

**Working Activity**
□Sitting
□Standing
□Standing
□Light Labor
□Heavy Labor

**Habits**
□Smoking: Packs/Week_____
□Alcohol: Dinks/Week_____
□Coffee/Caffeinated Drinks: Cups/Day_____
□High Stress Leve: Reason_____

Are you Pregnant? □Yes □No Due Date:

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| Injuries/Surgeries you have had | Description | Date |
|---|---|---|
| Falls | | |
| Head Injuries | | |
| Broken Bones | | |
| Dislocations | | |
| Surgeries | | |

| Medications | Allergies | Minerals/Vitamins/Herbs |
|---|---|---|
| | | |
| | | |
| | | |

Pharmacy Name/Number

**HIPPA NOTICE OF PRIVACY PRACTICES**

**This notice describes how medical information about you may be used and disclosed and how you can get access to this information.**

**Treatment:** We may use your health information to provide you with our professional services. Everyone on our staff is required to sign a confidentiality agreement.

**Disclosure:** We may disclose and/or share your healthcare information with other health care professionals who provide treatment and/or services to you. Health information about you may also be disclosed to those other persons you choose to involve in your care (i.e. your Massage Therapist(s).)

**Payment:** We may use and disclose your health information to seek payment for services we provide to you. This involves our office staff and/or insurance companies or other businesses that may be involved in the process of mailing statements and/or collecting unpaid balances.

**Emergencies:** We may use or disclose your health information to notify or assist in notifying your family or anyone else responsible for your care in case of an emergency. If you are incapacitated, we will use our professional judgment to only share your health information with those you have designated.

**Law:** We may use or disclose your health information as required by law including, but not limited to: court or administrative orders, subpoenas and discovery requests.

**Abuse/Neglect:** We may disclose your health information to appropriate authorities if we believe you are a possible victim of abuse, neglect or other crimes.

**Public Health Responsibilities:** We will disclose your health care information to report problems with or reactions to products, infection or disease exposure, injury, or disability.

**National Security:** The health information of military personnel may be disclosed to federal officials under certain circumstances if the information is required for lawful reasons.

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**Appointment Reminders:** We may disclose your health information to provide you with appointment reminders via voicemail messages or other correspondence.

In order to protect your privacy, we will **NOT** leave messages concerning your health info with anyone but you or your legal guardian, or leave your health information on an answering machine or in a voice mail box **UNLESS** you give written permission for us to leave messages for you as listed below:

HOME PHONE: YES NO (circle one) Number: _____

WORK PHONE: YES NO (circle one) Number: _____

CELL PHONE: YES NO (circle one) Number: _____

SPOUSE OR OTHER HOUSEHOLD MEMBERS: YES NO (circle one) Number: _____

**The message authorization will remain in effect until otherwise notified in writing.**

**Access:** Upon written request, you have the right to review or obtain copies of your health information. There may be a charge for copies or postage if these copies are mailed to you and/or more than 20 pages.

**Non-Routine Disclosures:** You have the right to a list of occurrences in which we disclosed your information for reasons other than routine reasons, treatment, payment or healthcare operations.

**Restrictions:** You have the right to request that we place restrictions on our use or disclosure of your health information. We do not have to agree to these additional restrictions, but if we do, we will abide by the agreement, except in emergency situations. Any restriction requests must be submitted in writing.

**Questions:** You have the right to file a complaint with us if you feel we have not complied with these privacy practices. If you choose to file a formal complaint with us or with the US Department of Health and Human Services, we will not retaliate in any way.

Please list all people, and their relationship to you, that we may discuss your appointments and other information with:

| Name: | Relationship: |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

_____ _____ _____

Patient Signature (or Guardian Signature) Date Date of Birth

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## 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:_____

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AUTHORIZATION FOR CHIROPRACTIC TREATMENT AND INFORMED CONSENT

**Please read each section carefully**. You may request a copy of this form for your own records.

Before you, the Patient, receive chiropractic care, it is important that you read this Consent and understand the nature and risks of chiropractic medicine. The practice of chiropractic medicine involves the adjustment, manipulation, and treatment of your body in which vertebral subluxations and other malpositioned articulations and structures may be interfering with the normal generation, transmission, and expression of nerve impulse between the brain, organs, and tissue cells, thereby causing disease.

Chiropractic adjustments, manipulations, and treatments are intended to restore the normal flow of nerve impulse which produces normal function and consequent health.

The Patient is encouraged to ask questions!

I, the undersigned Patient, understand there are risks and limitations associated with the practice of chiropractic medicine, including the use of chiropractic care, evaluation, diagnosis, adjustments, manipulations, massages and treatments by Chiropractic First. I hereby authorize Dr. Jennifer Jozwiak, and whomever she designates her assistants, to administer such treatments, therapy, manipulations and massages as she deems therapeutically necessary, to me or my minor child. I give my informed consent to receive chiropractic medicine and/or massage from Chiropractic First. I also understand that no doctor can or should guarantee any "cure" for any course of treatment and that no spinal correction therefore can be guaranteed. If any pre-payment is made, and you discontinue care for any reason, any unused portion of the pre-payment is refundable. An insufficient funds charge of **$30 will be charged for returned checks.**

I, the undersigned Patient, realize a notice of 24 hours is encouraged for canceled appointments so they may be filled with others needing care and to avoid a No Show charge**. I understand that a No Show means I did not come to my appointment or I was 15 minutes or later to my appointment. I understand the amount for a No Show is $75 for appointments both with Dr. Jozwiak and the massage therapists.** I also understand that the reminder calls are a courtesy and that it is my responsibility to keep track of all my scheduled appointments. Please call 907-463-3051 to cancel/change appointments.

**Records Release Authorization**

I hereby authorize Dr. Jennifer Jozwiak to release all medical information acquired from my examination, illness, or treatment to any doctor, insurance carrier, or attorney.

_____ _____

Patient Signature (or Guardian Signature) Date

_____ _____

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**PRINTED** Name (First/Last)

Date of Birth

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