

ABOUT THE PATIENT

Soda City Chiropractic, 2205 Main Street, Columbia, SC, 29201

Name _____ Today's Date _____ Birthdate _____ Age _____
 Address _____ City _____ State _____ Zip _____
 Home Phone _____ Cell Phone _____ Work Phone _____ Gender ☐ M
☐ F
 Significant Other's Name _____ Kid's Names and Ages _____
 Your Employer _____ Type of Work _____
 e-Mail Address _____ Have you been to a chiropractor before? ☐ No ☐ Yes
 Emergency Contact _____ ph # _____
 Name of Medical
 Doctor(s) _____

- I authorize the doctor or his staff to render care as deemed appropriate for me and / or my child.
- I authorize Soda City 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.
- I authorize assignment of my insurance benefits (if applicable) directly to the provider.
- 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.
- For my balance my preferred payment method is: ☐ Cash ☐ Check ☐ Credit Card ☐ Car/Work Ins.

REASON FOR SEEKING CARE

PRESENT COMPLAINTS

1. _____ How long has this been an issue? _____
 Is it: ☐ Dull ☐ Sharp ☐ Ache ☐ Numb / Tingle ☐ Stabbing ☐ Constant ☐ Occasional ☐ Staying the same ☐ Getting worse
☐ Mild ☐ Moderate ☐ Severe ☐ Worse in the morning ☐ Worse in evening ☐ Pain radiates to _____
 2. _____ How long has this been an issue? _____
 Is it: ☐ Dull ☐ Sharp ☐ Ache ☐ Numb / Tingle ☐ Stabbing ☐ Constant ☐ Occasional ☐ Staying the same ☐ Getting worse
☐ Mild ☐ Moderate ☐ Severe ☐ Worse in the morning ☐ Worse in evening ☐ Pain radiates to _____
 3. _____ How long has this been an issue? _____
 Is it: ☐ Dull ☐ Sharp ☐ Ache ☐ Numb / Tingle ☐ Stabbing ☐ Constant ☐ Occasional ☐ Staying the same ☐ Getting worse
☐ Mild ☐ Moderate ☐ Severe ☐ Worse in the morning ☐ Worse in evening ☐ Pain radiates to _____
 4. _____ How long has this been an issue? _____
 Is it: ☐ Dull ☐ Sharp ☐ Ache ☐ Numb / Tingle ☐ Stabbing ☐ Constant ☐ Occasional ☐ Staying the same ☐ Getting worse
☐ Mild ☐ Moderate ☐ Severe ☐ Worse in the morning ☐ Worse in evening ☐ Pain radiates to _____
5. Does your condition affect: ☐ Sleep ☐ Work ☐ Daily Routine ☐ Sitting ☐ Driving
6. What makes it better? _____
7. What makes it worse? _____
8. What Doctor's have you seen for this? _____

9. Type of treatment: _____

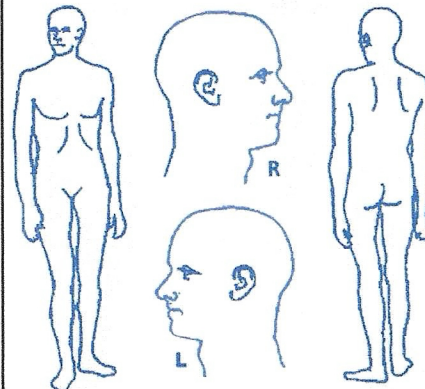
10. Results: _____

NOTES: _____

Are you pregnant?

☐ Yes ☐ No

Please mark all areas of concern.



GENERAL HEALTH HISTORY

Soda City Chiropractic, 2205 Main Street, Columbia, SC 29201

Patient Name _____ *Mark the conditions that apply to you.*

Past Present

- | | | |
|--------------------------|--------------------------|-------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Headaches |
| <input type="checkbox"/> | <input type="checkbox"/> | Migraines |
| <input type="checkbox"/> | <input type="checkbox"/> | Shortness of Breath |
| <input type="checkbox"/> | <input type="checkbox"/> | Allergies / Asthma |
| <input type="checkbox"/> | <input type="checkbox"/> | Medication Side Effects |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes |
| <input type="checkbox"/> | <input type="checkbox"/> | Hands or Feet cold |
| <input type="checkbox"/> | <input type="checkbox"/> | Muscle aches |
| <input type="checkbox"/> | <input type="checkbox"/> | Trouble Walking |
| <input type="checkbox"/> | <input type="checkbox"/> | Leg / Foot Numbness |
| <input type="checkbox"/> | <input type="checkbox"/> | Fainting |
| <input type="checkbox"/> | <input type="checkbox"/> | Gall Bladder Trouble |
| <input type="checkbox"/> | <input type="checkbox"/> | Ringing in Ears |
| <input type="checkbox"/> | <input type="checkbox"/> | Ear Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Sleeping Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Vision Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Thyroid Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Liver Disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Kidney Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Light Bothers Eyes |
| <input type="checkbox"/> | <input type="checkbox"/> | Other _____ |

Past Present

- | | | |
|--------------------------|--------------------------|------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Urinary Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Easy Bruising |
| <input type="checkbox"/> | <input type="checkbox"/> | Tobacco Use |
| <input type="checkbox"/> | <input type="checkbox"/> | Dental Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Fibromyalgia |
| <input type="checkbox"/> | <input type="checkbox"/> | Blood Thinner use |
| <input type="checkbox"/> | <input type="checkbox"/> | HIV Positive |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer |
| <input type="checkbox"/> | <input type="checkbox"/> | Depression |
| <input type="checkbox"/> | <input type="checkbox"/> | Alcohol Use |
| <input type="checkbox"/> | <input type="checkbox"/> | ___ High or ___ Low Blood Pressure |
| <input type="checkbox"/> | <input type="checkbox"/> | Stroke History |
| <input type="checkbox"/> | <input type="checkbox"/> | High Cholesterol |
| <input type="checkbox"/> | <input type="checkbox"/> | TMJ |
| <input type="checkbox"/> | <input type="checkbox"/> | Digestive Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Pain all Over |
| <input type="checkbox"/> | <input type="checkbox"/> | Tension / Irritability |
| <input type="checkbox"/> | <input type="checkbox"/> | Chest Pains |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Pacemaker |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Problems |

1. List any medications you are taking: _____

2. Please list all doctors you are currently seeing: _____

3. Has any Doctor or other professional advised you to "Go to a Chiropractor ": ☐ No ☐ Yes, Name _____

PAST HISTORY

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

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

6. List any past sport, recreational, or home injuries _____

7. Please describe any past conditions and treatment received: _____

8. Please list any past 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? _____

Paying for your care is easy here!

Mark and Initial which one is you:

- ☐ No Insurance: • Easy! Our Care Plans and simple payment arrangements have helped many people and will work great for you too!

Initial _____

- ☐ Health Insurance:

- Chiropractic care is a wellness procedure and no insurance company pays for wellness. Therefore we do not bill any health insurance.
- We don't fill out any insurance forms or provide any paperwork of any kind relating to health insurance.
- You pay us directly and enjoy a significant administrative savings.
- For your convenience, all payment arrangements are made in advance. We will never surprise you with a bill in the mail.

Initial _____

- ☐ Auto Injury:

- Auto related injuries are covered **100%** in South Carolina. Even if you were at fault or were a passenger. You can get the care you need and it costs you **\$0** Great for you!
- All we need is your claim number, insurance, and attorney info.

Initial _____

- ☐ Work Injury:

- Work injuries are covered with employer authorization or insurance carrier.
- All we need is your claim number and Work Comp ins. Info.

Initial _____

- ☐ Medicare:

- Regardless of your condition, Medicare pays for up to a maximum of 12 weeks of care. They have very strict rules and limitations.
- After this you will receive a significant Medicare discount.
- Medicare supplements normally don't pay anything.

Initial _____



Patient Consent for Chiropractic Treatment

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask your Doctor any questions that you have about the information below. You can ask questions at any time before, during, or after your treatment. The nature of chiropractic adjustment: The primary treatment your Doctors of Chiropractic uses is spinal manipulative therapy. We will use that procedure to treat you. We may use our hands or a mechanical instrument upon your body in such a way as to move your joints. This may cause an audible "pop" or "click", much as you have experienced when you "crack" your own knuckles. You may also feel a sense of movement. Examination and Treatment: In addition to spinal manipulation, we may use a variety of other therapies and examination procedures. As a part of the analysis, examination, and treatment, you are consenting to the following additional procedures: radiographic studies, heat, mechanical traction, massage, decompression. We will explain these procedures to you and answer any questions you have about them. The material risks inherent in chiropractic adjustment: Some patients will feel some stiffness and soreness following the first few days of treatment. We will make every reasonable effort during the examination to screen for contraindications to care. However, if you have a condition that would otherwise not come to our attention, it is your responsibility to inform us. As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myopathy, costovertebral strains and separations, and burns. 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. Chiropractic is a safe and comfortable form of health care for most people. If a potential risk is identified, you will be informed and offered either treatment or a referral to the appropriate health care specialist for evaluation and care.

The probability of risks occurring:

Soreness: It is not uncommon to experience some localized soreness following a manipulation. This type of soreness is usually minor and occurs most often following the initial few visits. It is similar to the soreness you may experience after exercise. **Fracture:** Fractures caused from spinal manipulations are extremely rare. It is so rare that an actual number of incidences per manipulation have never been determined. Patients suffering from bone weakening conditions like Osteoporosis are in a higher risk category. Alternative forms of spinal manipulation may be utilized for this type of patient. **Ruptured/Herniated Disc:** There have been some reports of herniated or ruptured discs caused by spinal manipulations. Alternative spinal adjusting methods are often utilized to minimize the risk and help the patient recover from serious disc-related pain. **TIA/Stroke:** According to the literature, possible neurological complications can arise in 1 per 1-8 million office visits or 1 per 2-5.85 million adjustments. Screening tests are performed when necessary to rule out high-risk patients. Alternative spinal adjusting is utilized when necessary to minimize any potential risks. Other complications: These include but are not limited to: dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns.

The risks and dangers associated with remaining untreated: Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

Notices of Privacy Practices: Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. These rights are more fully described in the Notice of Privacy Practices. We will provide you with a copy of the revised Notice of Privacy Practices upon your request.

Consent to Release of Information:

- In accordance with South Carolina Statutes § 42-15-95, I consent to the release by my provider of my health records and medical information about me to physicians, providers, and staff as necessary for treatment, to insurers as necessary to receive payment for services, and to third parties for purposes of reviewing quality of care and for health care operations (so long as the release is in compliance with applicable law), including releases for internal or external audits, research and quality assurance, or licensing/accreditation purposes.
- I give my permission to my provider to communicate information about me to those people involved in my care for the purpose of my treatment as designated in my medical record.
- I give permission for my provider to communicate with me regarding my medical care, such as results of tests/reports through voicemail messages via the phone numbers I have supplied in my medical record.
- In order to assure proper quality and continuity of care, I authorize Medicare, my insurance company or health maintenance organization, other payers, payer network organizations, or third party administrators to share my health records and information obtained from my health care provider or any other provider, with my health care provider, other providers from whom I have received services, or any other payer, payer network organization, or third party administrators as needed for payment and health care operations.

I understand this Consent to Release of Information does not expire unless I revoke it or provide a specific expiration date here:_____

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE. BY SIGNING BELOW, I CONSENT TO ALL OF THE USES AND DISCLOSURES ABOVE, AND I ACKNOWLEDGE THAT I HAVE BEEN OFFERED A COPY OF THE NOTICE OF PRIVACY PRACTICES.

I have read [] or have had read to me [] the above explanation of the chiropractic adjustment and related treatment. I have discussed it with my provider and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. I do not expect the doctor to be able to anticipate and explain all the risks and complications. Having been informed of the known risks, I hereby give my consent to that treatment. I intend this consent to apply to all of my present and future chiropractic care. I authorized Soda City Chiropractic to administer treatment for the minor listed even if I am not present.

Date

Signature of patient or authorized person

Authority to act on behalf of patient (Proof required)