BRILL
FAMILY CHIROPRACTIC

PATIENT INFORMATION

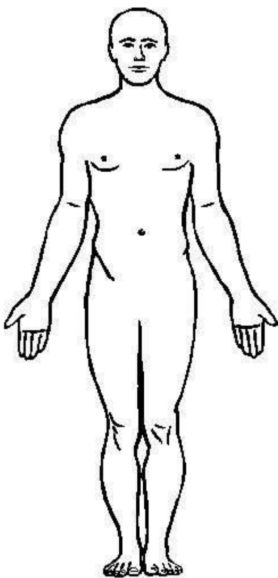
Last Name: ______________________ First Name:_______________________MI:_________
What would you prefer to be called?:___________________Marital Status:________________
SSN:____________________Date of Birth:______________________Age:________
Home Phone:_____________________________Cell Phone:____________________________
Address:______________________________City:_________________State/Zip:____________
Email:____
Occupation:________________Employer:___________________Work Phone:_____________

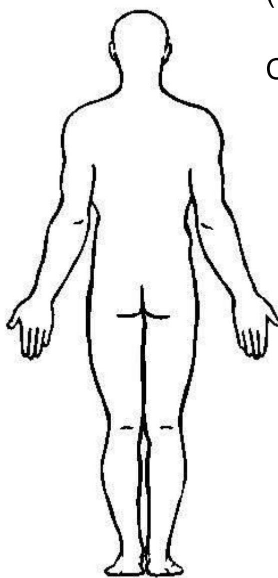
EMERGENCY CONTACT INFORMATION

Emergency Contact:___________________________________Relationship:______________
Primary Phone Number:_________________Secondary Phone Number:__________________

REFERRAL/ PURPOSE

How did you hear about our office?:____
Purpose of this appointment:____
When did your condition begin?:____
Was your conditions related to an accident or injury?____________________________________
Have you had similar symptoms before? YES NO Date of prior symptoms_____________





List chief symptoms in order of severity:
(1)____
(2)____
(3)____

Check all symptoms that apply to you at this time:

- ☐ Headache
- ☐ Neck pain/ stiffness
- ☐ Back pain/ stiffness
- ☐ Pain in extremity____________________
- ☐ Tingling/numbness in arms/hands
- ☐ Loss of balance/ dizziness
- ☐ Shortness of Breath
- ☐ Constipation
- ☐ Respiratory Infection
- ☐ Trouble Sleeping
- ☐ Other:______________________________

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PATIENT HEALTH INFORMATION

Allergies:____

Current Medications:

____

____

Surgical History (include dates if known):

____

SOCIAL:

In what position do you sleep?: Side Stomach Back Do you sleep well?: ________________

Exercise: 0 1 2 3 4 5 6 7 days/wk _______min Diet: Balanced Fair Poor Excessive

Do you use?: O Caffeine O Tobacco O Nicotine O Recreational Drugs O Alcohol

Describe the physical demands of your work: O Heavy O Moderate O Mild O Sedentary

GENERAL:

O Diabetes
O Fatigue
O Excessive Thirst
O Mental Disorder
O Night Sweats
O Cancer:_____________
O Recent Unexplained Weight Loss
O Loss of Appetite
O Other: ________________

MUSCULOSKELETAL/ NEUROLOGIC:

O Fractures
O Slipped Disc
O Deformity
O Osteoarthritis
O Stroke
O Gout
O Dizziness/ Vertigo
O Other: _________________
O Osteoporosis
O Herniated Disc
O Difficulty Walking
O Rheumatoid Arthritis
O Seizures
O Lupus
O Difficulty Swallowing
O Sprain or Strain __________
O Joint pain
O Weakness
O Paralysis
O Numbness or Tingling
O Scoliosis
O Tremors

CARDIOVASCULAR:

O Pacemaker/ ICD
O Anemia
O Blood/ Clotting Disorder
O Swelling
O High Blood Pressure
O Chest pain
O High Cholesterol
O Irregular Heart Rhythm
O Congestive Heart Disease
O Heart Attack
O Peripheral Vascular Disease
O Other: _________________

GI/ GU:

O Liver Disease
O Chronic Constipation
O Difficulty Swallowing
O Kidney Stones
O Gallbladder Disease
O Acid Reflux
O Chronic UTI
O Kidney Disease
O Abdominal Pain
O Hiatal Hernia
O Loss of bladder/ bowel func.
O Other: _________________

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PATIENT HEALTH INFORMATION CONTINUED

RESPIRATORY:

O Asthma
O COPD
O Difficulty breathing
O Chronic Resp. Infection
O Shortness of breath
O Other:__________________

HEAD/ NECK REGION:

O Headaches/ Migraines
O Double Vision
O Sinus Issues
O Neck lump/ pain
O Snoring
O Ear Pain
O Jaw or Chewing Issues
O Ringing in Ears
O Vestibular Issues/ Dizziness
O Other: _________________

REPRODUCTIVE/ HORMONAL/ IMMUNOLOGY/ BLOOD:

O Anemia
O Clotting Disorder
O Frequent Illness
O Swollen Lymph Nodes
O Seasonal Allergies
O Menstrual Issues
O Infertility
O Testicular/ Prostate Pain
O Other: _________________

_____ Initial Here if you have read and completed the health information in this form to the best of your ability.

ADD ANY OTHER NOTES HERE YOU WOULD LIKE FOR YOUR DOCTOR TO KNOW:

NOTICE OF PRIVACY PRACTICES AND AUTHORIZATION RELEASE CONSENT

NOTICE OF PRIVACY PRACTICES: We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. A brief listing of our privacy practices are listed below. If you would like to have a more detailed account of our policies and procedures concerning the privacy of you Patient Health Information, we encourage you to read the HIPPA Notice this is available to you at the front desk before signing this consent. If there is anyone specifically that you do not want to receive your medical records, please inform the office.

- Authorizations: Brill Family Chiropractic use and disclosure will be made only with specific authorizationform the individual
  - For uses and disclosures of "marketing purposes"
  - For uses and disclosures that constitute the sale of PHI
- Breach notification statement: Brill Family Chiropractic must notify an affected individual of a breach of unsecured PHI
- Restrict disclosure: Brill Family Chiropractic will restrict disclosures of protected Health Information to health plans if an individual has paid for services completely out of pocket.

INSURANCE INFORMATION:

Would you like us to bill your insurance for you? **Yes** **No**

Health Insurance

Policy holder: Name ___________________________________ Date of Birth ____________

Accident Insurance

Are you planning to use Aflac or any other Accidental Insurance? **Yes** **No**

Is your condition due to an accident? **Yes** **No** Date of Accident:____________

Accident Insurance Name______________________________ Claim #___________________

Adjuster Name _______________________________________ Phone #___________________

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payers and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable. I, (the patient) understand and agree to allow this chiropractic office to use their Patient Health Information for the purposes of treatment, payment, healthcare operations, and coordination of care.

I consent to the receipt of the "Notice of Privacy Practices" and "Authorization and Release" (if applicable).

PATIENT NAME: _____________________ PATIENT SIGNATURE:_____________________

WITNESS:__________________________ DATE:__________________

Documentation of Good Faith Effort to Distribute Notice of Privacy Practices:

__ Attempted to distribute; patient/guardian declined to acknowledge receipt of the above notice
__ Patient/ guardian stated they had already received the Notice
__ Notice of Privacy Practices was mailed to the patient
__ Other

CONSENT FOR CHIROPRACTIC TREATMENT

The primary treatment used by Doctors of Chiropractic is spinal manipulation or “adjustment” of the spine or extremities. I will use this procedure as part of your treatment program.

The nature of chiropractic manipulation:
I will use my hands to manipulate or loosen and reposition the joints of your spine or extremities. Often, with this procedure, you will hear a popping noise which is associated with your chiropractic manipulation. This popping noise, known as joint cavitation, is a completely normal and healthy part of the process when performed by a chiropractic professional.

The material risks inherent to chiropractic manipulation:
As with any health care procedure, there are certain complications that may arise from chiropractic manipulation. These complications may include aggravation of the degenerative or injured spinal discs, rib fractures, ligaments sprains, muscle strains, and/or nerve injury to arteries in the neck leading to or contributing to stroke. Local soreness and/or stiffness are typical inthe early phases of treatment.

Probability of those risks occurring:
Fractures are rare occurrences and generally result form underlying bone weakness, which I check for during your history and physical examination and/or with x-rays (if applicable). The exact incidence of stroke is incertain, but it is generally believed to occur in less than one in 1 million treatments. I employ physical tests that are advocated to screen for this risk, but they are generally accepted as being insensitive. All other complications are also generally described as rare.

Other treatment options:
- Over-the-counter medications and/or rest
- Medical care, which may include anti-inflammatory drugs, muscle relaxants, and pain medications
- Surgical Treatment- reserved for those cases where extensive conservative treatments have been tried.

I have read the above explanation of chiropractic manipulations, adjustment, and related treatments. I have discussed my options with my doctor and have had all questions answered to my satisfaction. By signing below, I state I have been informed of the risks and benefits of chiropractic treatment, I acknowledge it is within my best interest to undergo this treatment, and I give my consent to treatment.

PATIENT NAME: ______________________ PATIENT SIGNATURE:______________________

WITNESS:____________________________ DATE:________________

CONSENT TO TREAT A MINOR

I, being parent, guardian, or custodian of the named minor patient **______________________________,** do hereby authorize, request and direct Brill Family Chiropractic and its doctors and staff to perform examinations, testing, and treatment that in thier judgement, is deemed advisable or required. It is the understanding of the undersigned that the physician and their staff will have full authority from me as legal parent/ guardian to continue examinations, diagnostic tests, and treatments as will be needed while said minor shown above is under care in this office until legal age is attained. As legal parent/ guardian, I realize full responsibility for all charges and payments due.

PARENT/ GUARDIAN SIGNATURE: _________________________________ DATE: ______________

WITNESS:_____________________________