Red Rock Chiropractic Center

Adult New Patient Form

OFFICE USE ONLY
Height_____ Weight_____
BP_____
Pulse_____Shoe Size_____

PATIENT INFORMATION

Title: ☐Mr. ☐Mrs. ☐Ms. ☐Miss ☐Dr. ☐Prof. ☐Rev. **Sex:** ☐M ☐F
First name: _____**Middle name:**_____
Last name: _____**Suffix:**_____
Preferred name (Nickname):_____
Age: _____ **Birth date:** _____/_____/_____
Address: _____
City: _____ **State:**_____ **Zip:** _____
Home phone: (____)_____ **Work phone:** (____) _____
Cell phone: (____) _____
Email:_____
Best contact method: ☐Home phone ☐Cell phone ☐Email
Is it ok to text for appointments/reminders? ☐Yes ☐No

MARITAL STATUS/SPOUSE INFORMATION

Marital status:☐Married ☐Separated ☐Single ☐Divorced ☐Widowed
Spouse name: _____
Spouse cell phone: (____) _____
Spouse employer: _____
Spouse job title:_____
Spouse employment status: ☐Full-time ☐Part-time ☐Not employed ☐Student ☐Self-employed ☐Retired

CHILDREN

Do you have any children? ☐Yes ☐No If yes, how many? _____

EMERGENCY CONTACT INFORMATION

Emergency contact name: _____
Emergency contact phone: (___)_____
Emergency contact alternate phone: (___)_____
Relationship to patient: _____

EMPLOYMENT INFORMATION

Employer: _____
City: _____State: _____ Zip: _____
Employer phone: (____) _____
Job title:_____
Employment status: ☐Full-time ☐Part-time ☐Not employed ☐Student ☐Self-employed ☐Retired

PRIMARY CARE PHYSICIAN

Primary care physician name:_____
Clinic name:_____
City:_____State: _____ Zip: _____
Phone: (___)_____

RECREATION/HOBBIES

What do you like to do in your free time (recreation/hobbies)?
_____
_____

REFERRAL SOURCE

How did you hear about us?
☐Website ☐Newspaper ☐Phone book ☐Radio_____
☐Physician_____☐Massage therapist_____
☐Referral/word of mouth_____

PRIMARY INSURANCE INFORMATION

Insurance company: _____
Policyholder name: _____
Relationship to patient: _____
Policy number: _____
Group number: _____
Person responsible for payment: _____
Deductible: _____ Amt met this year: _____Co-pay: _____

SECONDARY INSURANCE INFORMATION

Insurance company: _____
Policyholder name: _____
Relationship to patient: _____
Policy number: _____
Group number: _____
Person responsible for payment: _____
Deductible: _____ Amt met this year: _____Co-pay: _____

PATIENT PREFERENCES

In the event you need to have therapy for greater than 5 minutes, what is your favorite music to listen to for relaxing?
_____

PREVIOUS CHIROPRACTIC CARE

Have you seen a chiropractor before? ☐No ☐Yes
If yes, when was the last time you have seen one? _____
How many chiropractic visits have you had this year? _____

ADDITIONAL SERVICES

Please mark any services besides chiropractic adjustments you might be interested in receiving here: ☐Decompression ☐Hydromassage ☐Food sensitivity testing ☐Blood/lab testing for an in-depth health analysis ☐DOT physicals ☐Sports physicals ☐In-office rehab ☐Custom-made orthotics ☐Custom-made pillows ☐Drug/alcohol testing for your business ☐Functional medicine ☐MLS laser therapy ☐Weight loss ☐Exercise program ☐Pre-employment physicals

REASON FOR VISIT

What brings you to our office today? ☐Pain/symptom relief ☐Problem correction/prevention ☐Wellness/Overall health
In your own words, tell us what you are looking for help with: _____
_____

Health Questionnaire

Current Conditions

Please mark the conditions for which you would like to be seen today:

☐ Headaches ☐Jaw pain ☐Neck pain ☐Shoulder pain ☐Arm pain ☐Wrist pain ☐ Hand pain ☐Upper back pain ☐ Mid back pain
☐Lower back pain ☐Hip pain ☐Knee pain ☐Leg pain ☐Ankle pain ☐Foot pain ☐Other_____

Other Treatment

Please list any other treatments you have received and the providers you have seen for these conditions:

☐Chiropractic _____ ☐Neurology_____ ☐Massage_____
☐Medication_____ ☐Physical therapy_____ ☐Surgery _____
☐Other_____

Daily Living Effects

Please mark which activities are affected by the above conditions: ☐Employment ☐Homemaking ☐Lifting ☐Personal care (washing, dressing, etc.) ☐Sitting ☐Sleeping ☐Social life ☐Standing ☐Traveling ☐Driving ☐Walking ☐Exercise ☐Other _____

What is the most important thing you want to be able to do that you're currently not able to because of the condition(s)?

_____

Feet/Orthotic History

What is your shoe size AND width? _____ Do you currently wear orthotics? ☐No ☐Yes
If yes, from where did you get them? ☐Podiatrist ☐Chiropractor ☐Store (Walmart, etc.) ☐Other_____
How many days per week do you wear these kinds of shoes? Athletic _____ Dress _____ High Heels _____ Flats _____Industrial_____

Accidents, Injuries, Fractures, & Hospitalizations

Please list any previous accidents, injuries, fractures, and hospitalizations and approximate date of occurrence.

Accident & Date	Injury & Date	Fracture & Date	Hospitalization & Date
☐No previous accidents	☐No previous injuries	☐No previous fractures	☐No previous hospitalizations
1.	1.	1.	1.
2.	2.	2.	2.
3.	3.	3.	3.
4	4	4.	4

Diagnostic Imaging

Please list any diagnostic imaging and approximate date of occurrence.

X-ray & Date	MRI & Date	CT Scan & Date	Bone Density & Date
☐No previous x-rays	☐No previous MRIs	☐No previous CT Scans	☐No previous bone densities
1.	1.	1.	1.
2.	2.	2.	2.
3.	3.	3.	3.
4	4	4.	4

Surgeries

Please list any previous surgeries and list the approximate date of occurrence.

Surgery/Year	Surgery/Year	Surgery/Year	Surgery/Year

General Health History

STRESS

Please circle your daily stress level: 0 1 2 3 4 5 6 7 8 9 10 Have you ever sought help for a mental health issue? ☐Yes ☐No

SLEEPING PATTERN

Please circle how many hours of sleep you get per night: 0 1 2 3 4 5 6 7 8 9 10 What is your sleep quality? ☐Excellent ☐Good ☐Fair ☐Poor
Please circle how many times your sleep is interrupted per night: 0 1 2 3 4 5 6 7 8 9 10

Current Medications/Vitamins

Please list current medications and vitamins including dosage, if known. ☐I am currently not taking any medications.

Medication Name	Dosage & Frequency	Medication Name	Dosage & Frequency
1.		5.	
2.		6.	
3.		7.	
4		8.	

Women Only

Are you pregnant? ☐Yes ☐No ☐Unsure If pregnant, what is your due date? ____/____/_____

Social History

Caffeine used ☐Often ☐Occasionally ☐Never	**Chew tobacco** ☐Often ☐Occasionally ☐Never	**Smoke tobacco** ☐Often ☐Occasionally ☐Never
Drink alcohol ☐Often ☐Occasionally ☐Never	**Exercise** ☐Often ☐Occasionally☐Never	**Wear seatbelt** ☐ Always ☐Usually ☐Never

Family History

Alzheimer's ☐Parent ☐Sibling	Diabetes ☐Parent ☐ Sibling	Osteoporosis ☐ Parent ☐Sibling
Arthritis ☐Parent ☐Sibling	Epilepsy ☐Parent ☐ Sibling	Psychiatric ☐ Parent ☐Sibling
Cholesterol ☐Parent ☐Sibling	Heart problems ☐Parent ☐Sibling	Stroke ☐Parent ☐Sibling
Cancer ☐Parent ☐Sibling	High blood pressure ☐Parent ☐ Sibling	Thyroid ☐ Parent ☐Sibling

Substance Abuse

Alcohol ☐Past ☐Present	Cocaine ☐Past ☐Present	Marijuana ☐Past ☐Present
Amphetamines ☐Past ☐Present	Crystal Meth ☐Past ☐Present	Other ☐Past ☐Present
Barbiturates ☐Past ☐Present	Heroin ☐Past ☐Present	

ALLERGIC/IMMUNOLOGIC				☐I have had none of these conditions.	
Allergy shots	☐Present ☐Past	Hay fever	☐Present ☐Past	Hives	☐Present ☐Past
Cortisone use	☐Present ☐Past	HIV/AIDS	☐Present ☐Past	Immune disorder	☐Present ☐Past
CARDIOVASCULAR				☐I have had none of these conditions.	
Angina	☐Present ☐Past	Heart disease	☐Present ☐Past	Pace maker	☐Present ☐Past
Aortic aneuyism	☐Present ☐Past	High blood pressure	☐Present ☐Past	Poor circulation	☐Present ☐Past
Calf pain	☐Present ☐Past	High cholesterol	☐Present ☐Past	Rheumatic fever	☐Present ☐Past
Chest pain	☐Present ☐Past	Hot feet/hands	☐Present ☐Past	Swelling of legs	☐Present ☐Past
Cold feet or hands	☐Present ☐Past	Irregular heartbeat	☐Present ☐Past	Varicose veins	☐Present ☐Past
Discolored feet/hands	☐Present ☐Past	Leg cramps	☐Present ☐Past	Vascular disease	☐Present ☐Past
Heart attack	☐Present ☐Past	Low blood pressure	☐Present ☐Past		
CONSTITUTIONAL				☐I have had none of these conditions.	
Difficulty sleeping	☐Present ☐Past	Fatigue	☐Present ☐Past	Weight loss/gain	☐Present ☐Past
Energy level problem	☐Present ☐Past	Insomnia	☐Present ☐Past		
EARS/NOSE/THROAT/MOUTH				☐I have had none of these conditions.	
Bleeding gums	☐Present ☐Past	Drainage	☐Present ☐Past	Jaw pain	☐Present ☐Past
Broken/knocked out teeth	☐Present ☐Past	Ear pain	☐Present ☐Past	Periodontal disease	☐Present ☐Past
Changes in taste	☐Present ☐Past	Frequent infection	☐Present ☐Past	Post nasal drip	☐Present ☐Past
Cold sores	☐Present ☐Past	Hearing loss	☐Present ☐Past	Ringing in ears	☐Present ☐Past
Difficulty swallowing	☐Present ☐Past	Hiccups	☐Present ☐Past	Sinus infection	☐Present ☐Past
Dizziness	☐Present ☐Past	Hoarseness	☐Present ☐Past	Snoring	☐Present ☐Past
ENDOCRINE				☐I have had none of these conditions.	
Diabetes	☐Present ☐Past	Menopausal	☐Present ☐Past	Pelvic inflammatory disease	☐Present ☐Past
Endometriosis	☐Present ☐Past	Menstrual cramps	☐Present ☐Past	Pre-menstrual syndrome	☐Present ☐Past
Fibroids	☐Present ☐Past	Menstrual problems	☐Present ☐Past	Thyroid disease	☐Present ☐Past
Hair loss	☐Present ☐Past	Ovarian cysts	☐Present ☐Past		
EYES				☐I have had none of these conditions.	
Blurred vision	☐Present ☐Past	Eye injury	☐Present ☐Past	Lazy eye	☐Present ☐Past
Cataracts	☐Present ☐Past	Eyestrain	☐Present ☐Past	Macular degeneration	☐Present ☐Past
Changes in vision	☐Present ☐Past	Floaters and flashes	☐Present ☐Past	Sensitivity to light	☐Present ☐Past
Cross eye	☐Present ☐Past	Glasses/contacts	☐Present ☐Past	Spots in vision	☐Present ☐Past
Double vision	☐Present ☐Past	Glaucoma	☐Present ☐Past		
GASTROINTESTINAL				☐I have had none of these conditions.	
Abdominal pain	☐Present ☐Past	Diverticulosis/ diverticulitis	☐Present ☐Past	Poor appetite	☐Present ☐Past
Bloody stools	☐Present ☐Past	Gallbladder problems	☐Present ☐Past	Rectal bleeding	☐Present ☐Past
Bowel problems	☐Present ☐Past	Heartburn/indigestion	☐Present ☐Past	Rectal pain	☐Present ☐Past
Constipation	☐Present ☐Past	Hemorrhoids	☐Present ☐Past	Ulcers	☐Present ☐Past
Diarrhea	☐Present ☐Past	Liver problems	☐Present ☐Past		
GENITOURINARY				☐I have had none of these conditions.	
Blood in urine	☐Present ☐Past	Foul odor of urine	☐Present ☐Past	Syphillis	☐Present ☐Past
Burning urination	☐Present ☐Past	Frequent urination	☐Present ☐Past	Trichomoniasis	☐Present ☐Past
Chlamydia	☐Present ☐Past	Gonorrhea	☐Present ☐Past	Urinary infection	☐Present ☐Past
Decreased urination	☐Present ☐Past	Incontinence	☐Present ☐Past	Vaginal yeast infection	☐Present ☐Past
Difficulty urinating	☐Present ☐Past	Kidney disease	☐Present ☐Past		
Enlarged prostate	☐Present ☐Past	Kidney stone	☐Present ☐Past		
HEMATOLOGIC/LYMPHATIC				☐I have had none of these conditions.	
Anemia	☐Present ☐Past	Easy bleeding	☐Present ☐Past	Sickle cell disease	☐Present ☐Past
Blood clots	☐Present ☐Past	Easy bruising	☐Present ☐Past	Skin cancer	☐Present ☐Past
Breast cancer	☐Present ☐Past	Hepatitis	☐Present ☐Past	Swollen glands	☐Present ☐Past
Breast lumps	☐Present ☐Past	Lung cancer	☐Present ☐Past		
Cancer (other)	☐Present ☐Past	Phlebitis	☐Present ☐Past		
Cirrhosis	☐Present ☐Past	Prostate cancer	☐Present ☐Past		
INTEGUMENTARY				☐I have had none of these conditions.	
Acne	☐Present ☐Past	Changes in moles	☐Present ☐Past	Shingles	☐Present ☐Past
Athlete's foot	☐Present ☐Past	Eczema	☐Present ☐Past	Skin disease	☐Present ☐Past
Bed sores	☐Present ☐Past	Itching	☐Present ☐Past	Skin ulcers	☐Present ☐Past
Boils	☐Present ☐Past	Psoriasis	☐Present ☐Past	Warts	☐Present ☐Past
Brittle nails	☐Present ☐Past	Rashes	☐Present ☐Past		
MENTAL HEALTH				☐I have had none of these conditions.	
Alcoholism	☐Present ☐Past	Marital/relationship problems	☐Present ☐Past	Schizophrenia	☐Present ☐Past
Anger	☐Present ☐Past	Mood swings	☐Present ☐Past	Self-esteem issues	☐Present ☐Past
Anxiety disorder	☐Present ☐Past	Obsessive compulsive disorder	☐Present ☐Past	Sexual concerns	☐Present ☐Past
Bipolar disorder	☐Present ☐Past	Panic attacks	☐Present ☐Past	Suicidal thoughts	☐Present ☐Past
Burn out	☐Present ☐Past	Paranoia	☐Present ☐Past	Unusual stress	☐Present ☐Past
Depression	☐Present ☐Past	Passive/aggressive behavior	☐Present ☐Past		
Drug overdose	☐Present ☐Past	Post-traumatic stress disorder	☐Present ☐Past		

MUSCULOSKELETAL				☐I have had none of these conditions.	
Arthritis	☐Present ☐Past	Masses	☐Present ☐Past	Repetitive motion injury	☐Present ☐Past
Bone pain	☐Present ☐Past	Muscle ache	☐Present ☐Past	Rheumatoid arthritis	☐Present ☐Past
Dislocations	☐Present ☐Past	Muscle weakness	☐Present ☐Past	Scoliosis	☐Present ☐Past
Gout	☐Present ☐Past	Osteoporosis	☐Present ☐Past	Sports injury	☐Present ☐Past
Joint pain	☐Present ☐Past	Polio	☐Present ☐Past	Sprains/strains	☐Present ☐Past
NEUROLOGICAL				☐I have had none of these conditions.	
Alzheimer's disease	☐Present ☐Past	Fainting	☐Present ☐Past	Seizures	☐Present ☐Past
Blacking out	☐Present ☐Past	Head injury	☐Present ☐Past	Severe Headaches	☐Present ☐Past
Brain aneurysm	☐Present ☐Past	Heat exhaustion/heat stroke	☐Present ☐Past	Spinning/Balance	☐Present ☐Past
Carpal tunnel	☐Present ☐Past	Multiple sclerosis	☐Present ☐Past	Stroke	☐Present ☐Past
Concussion	☐Present ☐Past	Parkinson's disease	☐Present ☐Past	Weakness	☐Present ☐Past
Dementia	☐Present ☐Past	Pinched nerves	☐Present ☐Past		
Dizziness	☐Present ☐Past	Poor coordination	☐Present ☐Past		
PRENATAL (Women only)				☐I have had none of these conditions.	
Ectopic pregnancies	☐Present ☐Past	Prenatal constipation	☐Present ☐Past	Prenatal upset stomach	☐Present ☐Past
Gestational diabetes	☐Present ☐Past	Prenatal headaches	☐Present ☐Past	Prenatal UTI	☐Present ☐Past
More than one pregnancy	☐Present ☐Past	Prenatal heartburn	☐Present ☐Past	Preterm labor	☐Present ☐Past
Prenatal anemia	☐Present ☐Past	Prenatal high blood pressure	☐Present ☐Past	Sexually transmitted disease	☐Present ☐Past
Prenatal bleeding	☐Present ☐Past	Prenatal insomnia	☐Present ☐Past		
RESPIRATORY				☐I have had none of these conditions.	
Asthma	☐Present ☐Past	Croup	☐Present ☐Past	Shortness of breath	☐Present ☐Past
Bronchitis	☐Present ☐Past	Emphysema	☐Present ☐Past	Tuberculosis	☐Present ☐Past
COPD	☐Present ☐Past	Pneumonia	☐Present ☐Past		

HIPAA Privacy Act

I have received RRCC, notice of HIPAA Privacy Act. I authorize RRCC to release to my insurance company, health plan, HMO, no-fault carrier, and/or workers' compensation carrier, any information including my complete health record needed to determine benefits for services provided by or on behalf of RRCC. I understand and agree that I am financially responsible to RRCC, for any and all charges not covered by insurance for myself, spouse, and dependents.

_____ _____

Patient or Legal Guardian Signature **Date**

Consent to Electronic Communication

I acknowledge the privacy risks associated with using electronic communications and authorize Red Rock Chiropractic Center staff and/or doctor to communicate with me or any minor dependent/ward for purpose of medical advice, education, clinical record summaries, full medical records, and/or appointment reminders. I understand that my e-mail address will not be given to anyone outside of this clinic for any reason and that this will be for medical purposes only.

_____ _____

Patient or Legal Guardian Signature **Date**

Insurance Assignment and Release:

I, the undersigned, certify that I (or my dependent) have insurance coverage with _____and assign directly to Red Rock Chiropractic Center 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 authorize the use of this signature on all insurance submissions.

_____ _____

Responsible Party Signature **Date**

I request that payment of authorized Medicare benefits be made of my behalf to Red Rock Chiropractic Center for any services furnished to me. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

_____ _____

Responsible Party Signature **Date**

Informed Consent Form

The doctor of chiropractic evaluates the patient using standard examination and testing procedures. A chiropractic adjustment involves the application of a quick, precise force directed over a very short distance to a specific vertebra or bone. There are a number of different techniques that may be used to deliver the adjustment, some of which utilize specially designed equipment. Adjustments are usually performed by hand but may also be performed by hand-guided instruments. Other treatments used by chiropractors include physical therapy modalities (heat, ice, ultrasound, soft-tissue manipulation), nutritional recommendations and rehabilitative procedures.

Chiropractic treatments are one of the safest interventions available to the public demonstrated through various clinical trials and indirectly reflected by the low malpractice insurance paid by chiropractors. While there are risks involved with treatment, these are seldom great enough to contraindicate care. Referral for further diagnosis or management to a medical physician or other health care provider will be suggested based on history and examination findings. Listed below are summaries of both common and rare side-effects/complications associated with chiropractic care:

Common [1,]

- Reactions most commonly reported are local soreness/discomfort (53%), headaches (12%), tiredness (11%), radiating discomfort (10%), dizziness, the vast majority of which resolve within 48 hours

Rare [2]

- Fractures or joint injuries in isolated cases with underlying physical defects, deformities or pathologies
- Physiotherapy burns due to some therapies
- Disc herniations
- Cauda Equina Syndrome[3] (1 case per 100 million adjustments)
- Compromise of vertebrobasilar artery (i.e. stroke) (1 case per 400,000 to 1 million cervical spine adjustments [manipulations]). This associated risk is also found with consulting a medical doctor for patients under the age of 42 and is higher for those older than 42 when seeing a medical doctor.[4, 5] These findings suggest that neither chiropractic or medical care is the cause, but rather because patients with a dissection in progress have symptoms of headache or neck pain they seek care from a health care provider. Please indicate to your doctor if you have a headache or neck pain that is the worst you have ever felt.

Reasonable alternatives to these procedures have been explained to me including prescription medications, over-the-counter medications, possible surgery, and non-treatment. Listed below are summaries of concern with the associated alternative procedures.

- Long-term use or overuse of medication carries some risk of dependency with the use of pain medication the risk of gastrointestinal bleeding among other risks
- Surgical risks may include unsuccessful outcome, complications such as infection, pain, reactions to anesthesia, and prolonged recovery.[6]
- Potential risks of refusing or neglecting care may result in increased pain, restricted motion, increased inflammation, and worsening of my condition.[7]

Neck and back pain generally improve in time, however, recurrence is common. Remaining active and positive improve your chances of recovery.

1. Senstad O, Leboeuf-Yde C, Borchgrevink CF. Side-effects of chiropractic spinal manipulation: types frequency, discomfort and course. *Scand J Prim Health Care.* Mar 1996;14(1):50-53.
2. Thiel HW, Bolton JE, Docherty S, Portlock JC. Safety of chiropractic manipulation of the cervical spine: a prospective national survey. *Spine.* Oct 1 2007;32(21):2375-2378; discussion 2379.
3. Shekelle PG, Adams AH, Chassin MR, Hurwitz EL, Brook RH. Spinal manipulation for low-back pain. *Ann Intern Med.* Oct 1 1992;117(7):590-598.
4. Boyle E, Cote P, Grier AR, Cassidy JD. Examining vertebrobasilar artery stroke in two Canadian provinces. *Spine.* Feb 15 2008;33(4 Suppl):S170-175.
5. Cassidy JD, Boyle E, Cote P, et al. Risk of vertebrobasilar stroke and chiropractic care: results of a population-based case-control and case-crossover study. *Spine.* Feb 15 2008;33(4 Suppl):S176-183.
6. Carragee EJ, Hurwitz EL, Cheng I, et al. Treatment of neck pain: injections and surgical interventions: results of the Bone and Joint Decade 2000-2010 Task Force on Neck Pain and Its Associated Disorders. *Spine.* Feb 15 2008;33(4 Suppl):S153-169.
7. Carroll LJ, Hogg-Johnson S, van der Velde G, et al. Course and prognostic factors for neck pain in the general population: results of the Bone and Joint Decade 2000-2010 Task Force on Neck Pain and Its Associated Disorders. *Spine.* Feb 15 2008;33(4 Suppl):S75-82.

Please check any appropriate boxes if it is true for you to help us determine possible risk factors:

QUESTION	YES	DOCTOR'S COMMENTS
GENERAL		
Have you ever had an adverse (i.e. bad) reaction to or following chiropractic care?	☐	
BONE WEAKNESS		
Have you been diagnosed with osteoporosis?	☐	
Do you take corticosteroids (e.g. prednisone)?	☐	
Have you been diagnosed with a compression fracture(s) of the spine?	☐	
Have you ever been diagnosed with cancer?	☐	
Do you have any metal implants?	☐	
VASCULAR WEAKNESS		
Do you take aspirin or other pain medication on a regular basis?	☐	
If yes, about how much do you take daily? _____	☐	
Do you take warfarin (Coumadin), heparin, or other similar "blood thinners"?	☐	
Have you ever been diagnosed with any of the following disorders/diseases?		
• Rheumatoid arthritis	☐	
• Reiter's syndrome, ankylosing spondylitis, or psoriatic arthritis	☐	
• Giant cell arteritis (temporal arteritis)	☐	
• Osteogenesis imperfect	☐	
• Ligamentous hypermobility such as with Marfan's disease, Ehlers-Danlos syndrome		
• Medial cystic necrosis (cystic mucoid degeneration)		
• Bechet's disease		
• Fibromuscular dysplasia		
Have you ever become dizzy or lost consciousness when turning your head?	☐	
SPINAL COMPROMISE OR INSTABILITY	☐	
Have you had spinal surgery?	☐	
If yes, when? _____		
Have you been diagnosed with spinal stenosis?	☐	
Have you been diagnosed with spondyliolithesis?	☐	
Have you had any of the following problems?		
• Sudden weakness in the arms or legs?	☐	
• Numbness in the genital area?	☐	
• Recent inability to urinate or lack of control when urinating?		

I also understand that my condition may worsen and referral may be necessary if a course of chiropractic care does not help or improve my condition. I have read the previous information regarding risks of chiropractic care and my doctor has explained my risks (if any) to me and suggested alternatives when those risks exist. I understand the purpose of my care and have been given an explanation of the treatment, the frequency of care, and alternatives to this care. All of my questions have been answered to my satisfaction. I agree to this plan of care.

_____ _____

PATIENT'S SIGNATURE **DATE** **DOCTOR'S SIGNATURE** **DATE**

AUTHORIZATION TO RELEASE INFORMATION

PLEASE PRINT CLEARLY

PATIENT'S
NAME_____
LAST FIRST INITIAL

ADDRESS_____
STREET CITY STATE ZIP

PHONE (_____)_____ BIRTH DATE_____ LAST 4 SSN_____

Please List Medical Facility:

1. NAME	2. NAME	3. NAME
ADDRESS	ADDRESS	ADDRESS
CITY STATE ZIP	CITY STATE ZIP	CITY STATE ZIP
PHONE NUMBER	PHONE NUMBER	PHONE NUMBER
FAX NUMBER	FAX NUMBER	FAX NUMBER

The type of information to be used or disclosed is as follows:

☐ _____ X-rays ☐Images (mailed) ☐ Radiology report (faxed) Dates requested _____
☐ _____ X-rays ☐Images (mailed) ☐ Radiology report (faxed) Dates requested _____
☐ _____ X-rays ☐Images (mailed) ☐ Radiology report (faxed) Dates requested _____
☐_____MRI ☐ Radiology report (faxed) Dates requested _____
☐_____MRI ☐ Radiology report (faxed) Dates requested _____
☐_____CT Scan ☐ Radiology report (faxed) Dates requested _____
☐ Lab work and current medication list Dates requested _____
☐Other _____

Please <u>mail</u> requested images and <u>fax</u> requested reports by _____.

<u>This information may be disclosed to and used by the following organization:</u>

KYLE J. PANKONIN, D.C.
RED ROCK CHIROPRACTIC CENTER
202 MAINS STREET, PO BOX 517
LAMBERTON, MN 56152
PHONE: 507-752-7650
FAX: 507-752-7635

The reason for disclosure of this information is for the following reason:

☒Continuing healthcare ☐Personal ☐Other_____

I understand I have a right to revoke this authorization at any time by presenting a written revocation to the medical record department. I understand the revocation will not apply to:

- Information already released in response to this authorization
- My insurance company when the law provides my insurer with the right to contest a claim under my policy.

I understand authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules.

Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____. If I fail to specify an expiration date, event, or condition, this authorization will be in effect for one year from this date, for records generated as a result of services occurring on or prior to this date.

SIGNED_____DATE_____
(IF NOT PATIENT, STATE RELATIONSHIP)