Welcome

About You

Date: _____

Patient Name _____ (**Last**) _____ (**First**) _____ (M.I.)

Male ☐ Female ☐ Nickname: _____

Birthdate _____ Age _____ SS# ___ - ___ - _____

Mailing Address _____ Apartment _____

City _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____ Mobile _____

Email Address _____

Occupation _____

Employer _____ How Long? _____

Emergency Contact _____

Emergency # _____

Status: Minor ☐ Single ☐ Dating ☐ Married ☐ Divorced ☐ Widowed ☐

Who may we thank for your referral? _____

Have you been to a chiropractor in the past? ☐ Yes ☐ No

Your Health History

Date of last:

Physical Exam _____ Spinal X-Ray _____

Spinal Exam _____ MRI, CT or Bone Scan _____

Place a mark on "Yes" or "No" to indicate if you've had any of the following:

AIDS/HIV	☐ Yes ☐ No	Gout	☐ Yes ☐ No	Pinched Nerve	☐ Yes ☐ No
Allergies	☐ Yes ☐ No	Heart Disease	☐ Yes ☐ No	Polio	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No	Prostate Issues	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	Hernia	☐ Yes ☐ No	Rheum. Arthritis	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Herniated Disk	☐ Yes ☐ No	Sinus Condition	☐ Yes ☐ No
Backaches	☐ Yes ☐ No	Migraine Headaches	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Other Headaches	☐ Yes ☐ No	Thyroid Issues	☐ Yes ☐ No
Concussion	☐ Yes ☐ No	Multiple Sclerosis	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Muscular Dystrophy	☐ Yes ☐ No	Tumors	☐ Yes ☐ No
Digestive Disorder	☐ Yes ☐ No	Neuritis	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No
Dizziness/Vertigo	☐ Yes ☐ No	Numbness	☐ Yes ☐ No	Other	
Emphysema	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No	_____	
Epilepsy	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No	_____	
Fractures	☐ Yes ☐ No	Parkinson's Disease	☐ Yes ☐ No		

EXERCISE
- ☐ None
- ☐ Moderate
- ☐ Daily
- ☐ Heavy

WORK ACTIVITY
- ☐ Sitting
- ☐ Standing
- ☐ Light Labor
- ☐ Heavy Labor

HABITS
- ☐ Smoking/Vaping/Nicotine — Packs/Day _____
- ☐ Alcohol — Drinks/Week _____
- ☐ Coffee/Caffeine Drinks — Cups/Day _____
- ☐ High Stress — Reason _____

Are you pregnant? ☐ Yes ☐ No Due Date _____

Please describe any injuries or surgeries you have had:

Back →

Your Concerns

What is your major complaint or concern? _____

When did your symptoms appear? _____

Are your symptoms ☐ constant? ☐ coming and going? ☐ getting worse? ☐ getting better?

What treatment have you already received for your condition? ☐ Medications ☐ Surgery

☐ Physical Therapy ☐ Chiropractic ☐ None ☐ Other _____

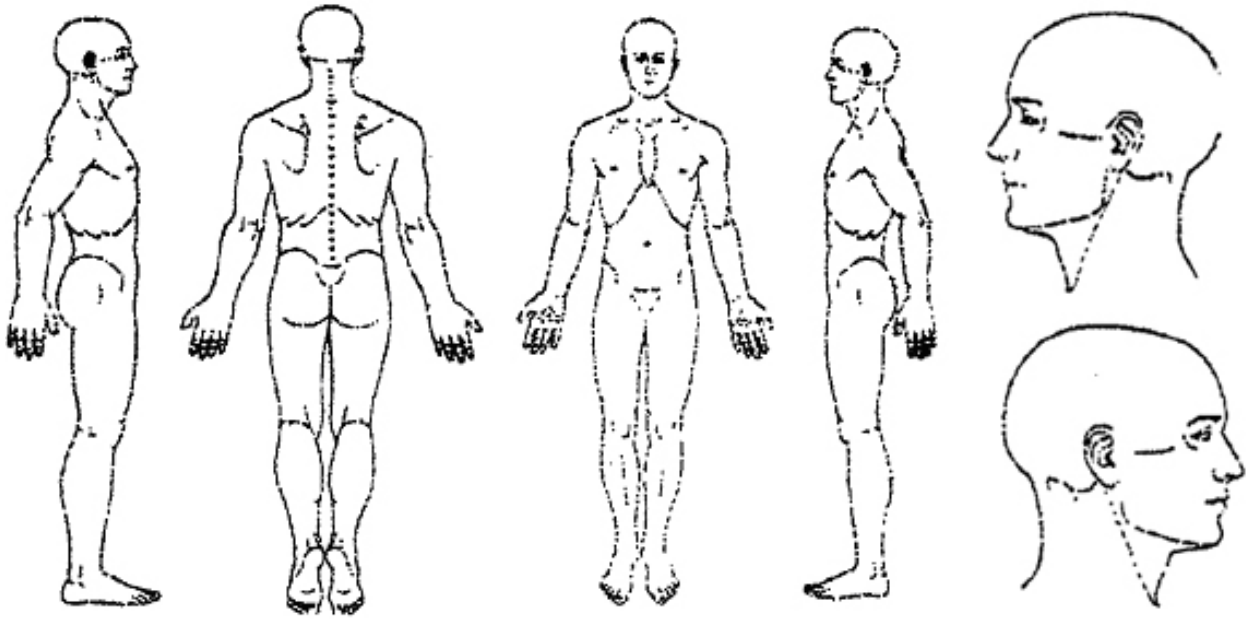
Other doctor(s) that treated you for this condition:

Rate the severity of your pain on a scale from 1 (least pain) to 10 (most pain) _____

Check type of pain:

☐ Sharp ☐ Dull ☐ Throbbing ☐ Aching ☐ Shooting
☐ Burning ☐ Numbness ☐ Tingling ☐ Stiffness ☐ Other

Place circles around the areas of discomfort



How often do you have this pain? _____

Does it interfere with Work ☐ Sleep ☐ Daily Routine ☐ Recreation ☐

Activities or movements that are painful to perform:

Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down ☐

Who else have you seen for this problem? _____

Other comments or concerns regarding your condition:

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient Signature _____ Date _____

If patient is under 18:
Guardian Signature _____ Date _____

North Country Chiropractic and Wellness, LLC

Patient Health Information Consent Form

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient understands that this office may periodically send mailed correspondence to her or his home including but not limited to birthday cards, letters of thanks, office promotional information, supplement information, and reactivation letters. In addition, this office may telephone patient's homes for the purpose of appointment reminders, rescheduling of missed appointments, or for billing inquiries.
3. The patient has the right to examine and obtain a copy of her or his own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
4. A patient's written consent need only be obtained one time for all subsequent care given to the patient in this office.
5. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
6. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
7. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
8. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Signature _____ Date _____

103 Elm Street Woodruff, WI 54568 715.358.6650

North Country Chiropractic & Wellness, LLC

Informed Consent For Chiropractic Treatment

By any standard, a chiropractic adjustment is a conservative and very safe procedure. However, we would like to notify you that there is a very remote possibility for injury from a chiropractic treatment.

According to a study by the Rand Corporation, a serious adverse reaction from a neck adjustment occurs once in 1 million manipulations. In contrast, the Journal of the American Medical Association found more than 2 million Americans became seriously ill each year from reactions to currently prescribed drugs. 106,000 of those people die from side effects.

I understand that there are risks to any treatment that I have. I also understand that my doctor has given me a treatment plan that best suits my condition and that I have that information to make my own decisions on whether or not to have the recommended treatment.

I understand the remote possibility of an injury from a chiropractic treatment and elect to receive the recommended treatment.

Patient Signature _____ Date _____

If patient is a minor: I hereby authorize Dr. Vijai Khan and whomever he may designate as his assistants to administer treatment as he so deems necessary to my child

_____

Missed Appointment Policy

We want to thank you for choosing us as your chiropractic health provider. In order to provide you and our other patients with the best optimal spine care, we request that you follow our guidelines regarding broken/cancelled appointments. Please remember that we have reserved appointment times especially for you. Therefore, we request at least 24 hours notice in order to reschedule your appointment. This will enable us to offer your cancelled time to other patients that desire to get their treatment completed. When you cancel your appointment at the last minute, everyone loses—you, the doctor, and other patients that would have liked to utilize your appointment time.

Since our office does not charge for broken or cancelled appointments, please realize how important it is to keep your reserved time. Thank you for your consideration of our policies and for the opportunity to be your chiropractic office of choice.

Patient Signature _____ Date _____