Thank you for choosing Jaicks Spine and Sport Chiropractic! To make your appointment more convenient, please take a few minutes to fill out the forms below. Completing this paperwork in advance will save you time, and allow us to become more familiar with your current complaints and past medical history immediately upon your arrival. If you have any additional questions or concerns, please feel free to contact Jaicks Spine and Sport Chiropractic at 724-220-4246. We hope your experience with us exceeds your expectations. Thank you again for making Jaicks Spine and Sport Chiropractic your choice to reduce pain and improve movement!

Sincerely,

Charles Jaicks, DC

Patient Name:_____ Date:_____

Address:_____

City:_____ State:_____ Zip:_____

Phone:_____ Email:_____

Age:_____ Gender:_____ D.O.B._____

Current Employer:_____

Job Title:_____

Emergency Contact:_____ Phone:_____

Family Physician:_____

Address:_____ Phone:_____

Who Is Responsible For Your Bill:_____

Patient Health Information Consent Form

We want you to know how your Patient Health Information (PHI) is going to be used, and your rights concerning those records. Before we begin any health care procedures 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 PHI, we encourage you to read the HIPAA NOTICE that is available upon request, before signing this consent.

1. The patient understands and agrees to allow this chiropractic practice to use their PHI for the purpose of treatment, payment, health care procedures and coordination of care. As an example, the patient agrees to allow this chiropractic practice to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the 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 has the right to examine and obtain a copy of his or her 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. This practice is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given to the patient by this practice.
4. 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.
5. 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 by this practice. We have taken all precautions known to this practice to assure that your records are not readily available to those who are not authorized to view them.
6. Patients have the right to file a formal complaint with our practice about any possible violation of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care procedures, the chiropractic physician has the right to refuse treatment.

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

Printed Name:_____

Signature:_____ Date:_____

To the patient: It is important that you understand the information contained within this document regarding the nature of chiropractic care and the risks/benefits associated. Please read the entire document and ask questions if you have any concerns prior to signing it.

The nature of the chiropractic adjustment:

One type of treatment I use as a Doctor of Chiropractic is *spinal manipulative therapy*. I may/may not use this procedure to treat you. I may use my hands upon your spine or extremities in such a way as to move your joints. This may cause an audible "pop" or "click" similar to what you would experience when you "crack" you knuckles. You may also feel movement in the joint.

Analysis/examination/treatment:

As part of the analysis, examination, and treatment, you are consenting to the following procedures (as clinically indicated): spinal manipulative therapy, range of motion assessment, manual muscle testing, palpation, orthopedic tests, posture analysis, vital signs, neurologic examination, therapeutic exercise, or manual therapy (use of the hands or instruments for treatment soft tissue: ie – massage, myofascial release, stretching, etc.). These services will only be provided with the patient's consent, and as indicated based on examination findings.

The risk(s) associated with spinal manipulative therapy:

As with many healthcare procedures, there are certain complications which may arise during chiropractic manipulation and therapy. These include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costo-vertebral strains and separation, burns, bruising or skin irritation. Some types of manipulation of the cervical spine have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. During the examination/evaluation you will be screened for any contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

The probability of those risks occurring:

Fractures are rare occurrences and generally result from some underlying pathology or disease of the bone. A review of your health history and examination will aid in assessing if there is any underlying bone disease which would contraindicate spinal manipulation. Stroke has been the subject of tremendous disagreement. The incidence of stroke is exceedingly rare and is estimated to occur between one in one million and one in five million cervical adjustments. The other above described complications are also generally considered rare.

The availability of other treatment options:

Other treatment options for your conditions may include: Self-administered over-the-counter analgesics and rest, medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain killers, hospitalization, or surgery.

If you chose to use one of the above noted "other treatments" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers of remaining untreated:

Remaining untreated may allow the formation of soft tissue/scar tissue adhesions and reduce joint mobility which may alter normal biomechanics and movement, resulting in pain, further reduced mobility, and possible injury. Over time this process may complicate treatment making it more difficult and less effective the longer treatment is postponed.

DO NOT SIGN UNLESS YOU HAVE READ AND UNDERSTAND THE ABOVE. PLEASE CHECK THE APPROPRIATE BOX AND SIGN BELOW.

I have read [ ] or have had read to me [ ] the above explanation of spinal manipulative therapy and related treatment. I have discussed this with Dr. Jaicks 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. Having been informed of the risks, I hereby give my consent to that treatment accordingly.

Patient's Name:_____ **Date:**_____

Patient's Signature:_____

Signature of Parent or Guardian/Caregiver:_____

Doctor's Name:_____ **Date:**_____

Doctor's Signature:_____

Name:_____ Date:_____File#:_____

Visual Analog Pain Scale

Indicate your **PAIN LEVEL** by circling the appropriate number on the scale below:

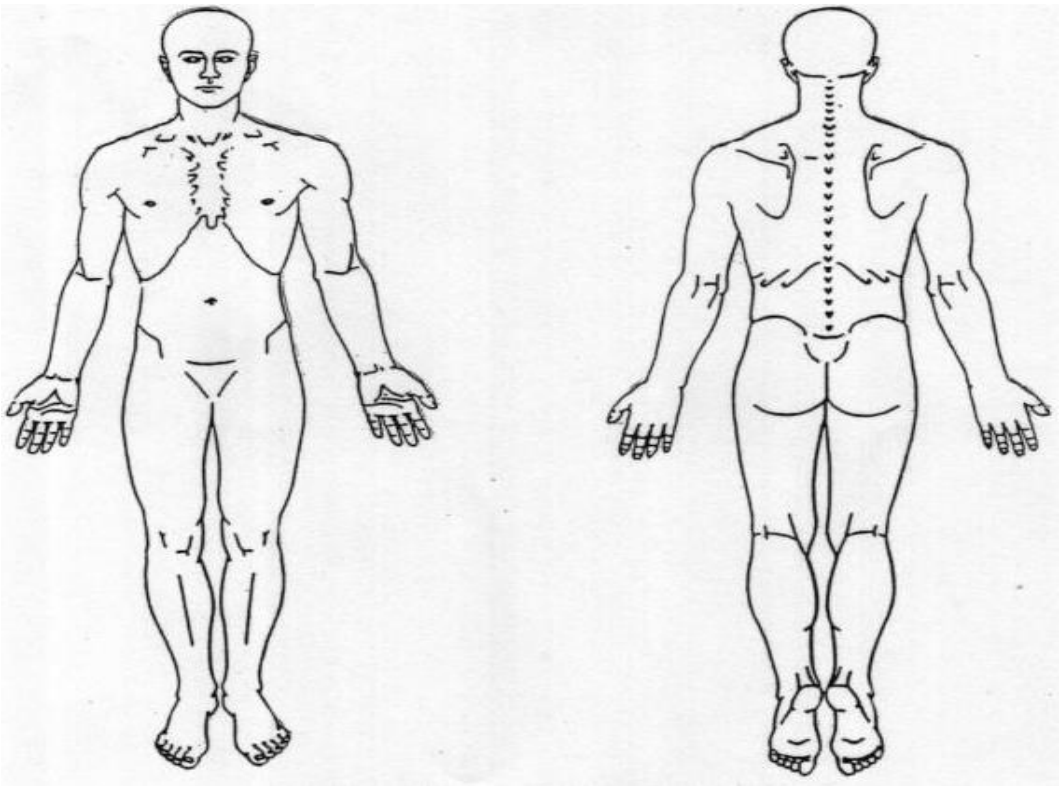
0 1 2 3 4 5 6 7 8 9 10

No Pain Moderate Pain EMERGENCY Pain!

Pain Diagram

Please mark the location of your symptoms using the following symbols:

Pain: XXX Numb/Tingling: OOOO Stiffness: ///// Other:_____



Medical History Information

Current Complaints:

a) Where is your pain?_____

b) How did it happen?_____

c) How would you describe your pain? Sharp, burning, stabbing, etc.?_____

d) How long has it been bothering you?_____

e) What seems to help your pain?_____

f) What activities are limited because of your pain?_____

g) Have you experienced any pain, numbness, or tingling in the arms or legs? Explain._____

h) Have you had any bowel/bladder problems, headaches, nausea, or **unexplained** fatigue since your current complaints began? Explain._____

i) Have you experienced any significant **unexplained** weight loss recently? Explain._____

j) Have you had any previous treatment for your current complaints? If so, what kind of treatment?_____

Exercise:_____Amount per day/week:_____

Smoker:_____Amount per day/week:_____

Alcohol:_____Amount per day/week:_____

Current Medications:_____

_____

Medical History Continued

Fractures:_____

Sprain/Strain Injuries:_____

Previous Injuries/Accidents:_____

Allergies to food or medication:_____

_____

Surgeries/Scars:_____

_____

History of Major Illness:

a) None: ☐
b) Heart:_____
c) Lungs:_____
d) Abdomen/Stomach:_____
e) Eyes, Ears, Nose:_____
f) Skin:_____
g) Brain/Nerves:_____
h) Kidney/Bladder:_____
i) Bowel/Colon:_____

Family History of Disease:

a) None: ☐
b) Mother:_____
c) Father:_____
d) Maternal Grandmother:_____
e) Maternal Grandfather:_____
f) Paternal Grandmother:_____
g) Paternal Grandfather:_____