Welcome to Evans Chiropractic

Please fill out and sign all
4 pages

Patient Information **Date: _____**

Name_____
First Middle Initial Last

Preferred name_____

SS#_____ Birth Date_____/_____/_____ Sex: ☐Female ☐Male
required for insurance

Address_____

City_____State_____Zip_____

Cell Phone # (_____)_____Email_____

In Case of Emergency person to contact :_____
Relationship: ☐ Parent ☐ Spouse ☐ Other _____
Phone #(_____)_____

Primary Care Physician_____

Employer/School_____Occupation_____
Phone # (_____)_____

How did you hear about us?_____

Patients under the age of 18 only

Responsible Party

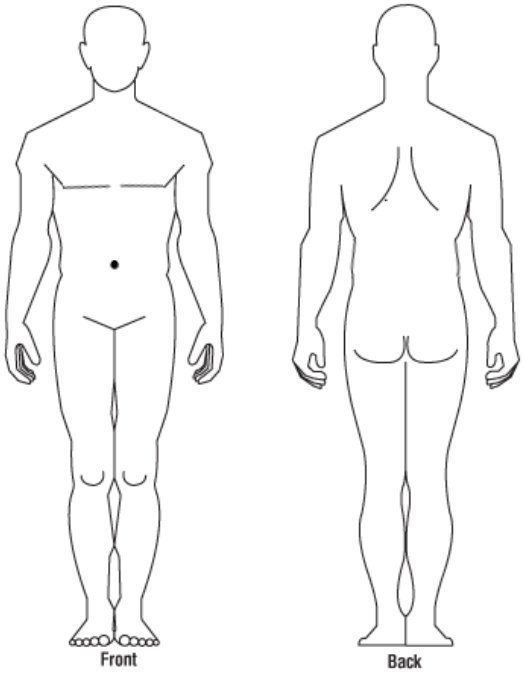
Name of person responsible for this account:_____
Relationship:_____ Phone # (_____)_____
Address_____
City_____State_____Zip_____

Symptoms

Reason for visit:_____
When did your symptoms start?_____
Is the condition getting better, worse or the same?_____
What makes it worse?_____
What makes it better?_____

Type of Pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting ☐ Headaches
☐ Burning ☐ Tingling ☐ Stiffness ☐ Other_____

Indicate where you are feeling your symptoms by drawing on the image



Check all of the activities that are difficult

☐ Sleeping
☐ Sitting
☐ Standing
☐ Walking
☐ Personal Care
☐ Lifting
☐ Driving
☐ Recreation
☐ Reading
☐ Concentration
☐ Work
☐ Dressing
☐ Dishes
☐ Vacuuming

Rate your Pain: (1 being mild pain to 10 being severe pain) 1 2 3 4 5 6 7 8 9 10

Have you felt this before? ☐ Yes ☐ No
What treatment have you already received?_____

Do you smoke? ☐ Yes ☐ No
Do you drink alcohol? ☐ Yes ☐ No

(Women)Are you Pregnant? ☐ Yes ☐ No Due Date:_____
Taking Birth Control ☐ Yes ☐ No

Health History

List any health history like cancer, osteoporosis, bone fractures, high blood pressure, strokes, epilepsy, seizures and/or recent surgeries, etc..._____
_____
_____

To the best of my knowledge, the above information is complete and correct.
_____ **Initials**

Insurance Policy

I certify that I, and /or my dependent(s), have insurance coverage, and assign directly to Dr. Evans/Dr. Hitchcock all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when written notice is given.

Privacy Policy

As of April 1, 2003, our office is implementing the requirements of the Health Insurance Portability and Accountability Act (HIPAA) which was passed by the federal legislature.

In brief, we do not share or release your personal or health information without your consent.

Your health information may be released in the event of a referral to another practitioner, or in case of emergency.

Financial Policy

Payment for services is due at the time services are rendered unless payment arrangements have been approved in advance by our staff. We accept cash, personal checks, debit cards, and major credit cards. We expect the deductible and copayment to be met at the time of your visit.

If you have health insurance, **we must emphasize that our relationship is with you, not your insurance company.** While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

If a balance remains on your account, a monthly statement will be sent. The first statement will be sent as a courtesy. Additional statements will include a $5 statement fee. We also reserve the right to charge interest (2% monthly) on outstanding balances and transfer unpaid accounts to a collection agency.

_____ _____

Print Name **Date**

_____

Signature

Evans Chiropractic

Informed Consent

I _____, do hereby give my consent to the performance of conservative noninvasive treatment to the joints and soft tissues. I understand that the procedures may consist of manipulations/adjustments involving the movement of the joints and soft tissues.
Physiotherapy and exercises may also be used.
Although spinal manipulation/adjustment is considered to be one of the safest, most effective forms of therapy for musculoskeletal problems, I am aware that there are possible risks and complications associated with these procedures as follows:
Soreness: I am aware that like exercise, it is common to experience muscle soreness and discomfort after spinal manipulation which usually fades within 24 hours.
Dizziness: Temporary symptoms like dizziness and nausea can occur, but are relatively rare.
Fractures/Joint Injury: I further understand that in isolated cases, underlying physical defects, deformities or pathologies like weak bones from osteoporosis, may render the patient susceptible to injury. When osteoporosis, degenerative discs, or other abnormalities are detected, this office will proceed with extra caution.
Stroke: Although strokes happen with some frequency in our world, strokes from chiropractic adjustments are rare. The chance that cervical manipulation will result in a serious reaction is remote, ranging from 1 in 1 million to 1 in 5.85 million manipulations.

Treatment Results

I also understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasm. However, I appreciate there is no certainty that I will achieve these benefits.
I realize that the practice of medicine, including chiropractic, is not an exact science and I acknowledge that no guarantee has been made to me regarding the outcome of these procedures.
I agree with the performance of these procedures by my doctor and such other persons of the doctor's choosing.

Alternative Treatments Available

Reasonable alternatives to these procedures have been explained to me, including rest, home applications of therapy, prescription or over-the-counter medications, exercises and possible surgery.
Medications: Medication can be used to reduce pain or inflammation. I am aware that long-term use or overuse of medication is always a cause for concern. Drugs may mask pathology, produce inadequate or short-term relief, undesirable side-effects, physical or psychological dependence, and may have to be continued indefinitely. Some medications may involve serious risks.
Rest/Exercise: It has been explained to me that simple rest is not likely to reverse pathology, although it may temporarily reduce inflammation and pain. The same is true of ice, heat or other home therapy. Prolonged bed rest contributes to weakened bones and joint stiffness. Exercises are of limited value but are not corrective of the injured nerve and joint tissues.
Non-treatment: I understand the potential risks of refusing or neglecting care may include increased pain, scar/adhesion formation, restricted motion, possible nerve damage, increased inflammation, and worsening pathology. The aforementioned may complicate treatment making future recovery and rehabilitation more difficult and lengthy.
I have read or have had read to me the above explanation of chiropractic treatment. Any questions I have had regarding these procedures have been answered to my satisfaction PRIOR TO SIGNING THIS CONSENT FORM. I have made my decision voluntarily and freely.

To attest to my consent to these procedures, I hereby affix my signature to the authorization for treatment.

_____ Signature of patient

_____ Date