Application for Chiropractic Treatment

Please complete all required fields marked with *

Patient's Name

First: | Middle: | Last:

Date of Birth

Month: | Day: | Year:

Address

Street Address:

Address Line 2:

City: | State / Province: | ZIP / Postal Code:

Mailing Address (if different)

Street Address:

Address Line 2:

City: | State / Province: | ZIP / Postal Code:

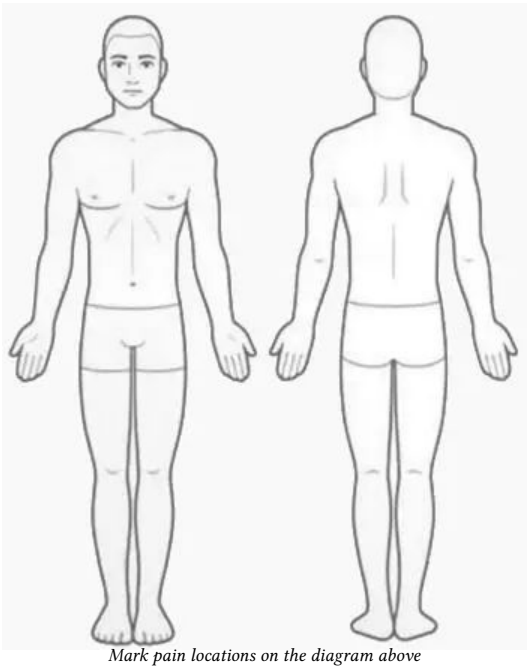
Home Phone

Cell Phone

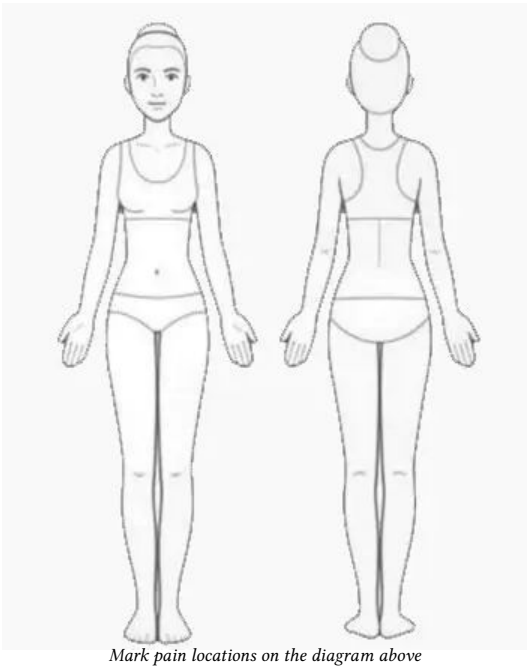
Sex

- ◯ Male
- ◯ Female

Please mark the exact location of your pain or symptoms on the diagrams below



Mark pain locations on the diagram above



Mark pain locations on the diagram above

Is patient a minor?

- ◯ Yes
- ◯ No

Relationship Status

- ◯ Single
- ◯ Married
- ◯ Divorced
- ◯ Widowed
- ◯ Separated

Number of Children

Parent or Guardian

First: Middle: Last:

Referred to our clinic by

Email

Enter Email: Confirm Email:

Are you employed?

- ◯ Yes
- ◯ No

Does your pain relate to a Workers Comp claim?

- ◯ Yes
- ◯ No

Where are you employed?

Employment Phone

Employer's Name

First:

Last:

Employment Address

Street Address:

Address Line 2:

City:

State / Province:

ZIP / Postal Code:

Does your pain relate to a motor vehicle accident?

- ◯ Yes
- ◯ No

Emergency Contact

Name

First:

Middle:

Last:

Relationship

Primary Phone

Secondary Phone

Authorization for Release of Your Patient Information: (optional)

Name

First:

Middle:

Last:

Relationship

Only complete this section if you answered YES to the question above.

Workers Comp Claim Form

Workers Comp Claim Form

We are very pleased you have chosen our doctors to get you back on the path to wellness after your Workers Comp injury.

We will be glad to forward your treatment plan and billing to your employer's insurance carrier. For us to do this it will be necessary to provide us with the following information in order to be seen on your appointment date.

Notify your employer that you will be seeing our doctors.

Employer HR Contact Name

First:

Last:

HR Contact Phone *

Name of the insurance company.

Address of your insurance company

Street Address:

Address Line 2:

City:

State / Province:

ZIP / Postal Code:

Insurance Phone

Name of the person handling your claim

First:

Last:

Their phone number

Claim Number

Only complete this section if you answered YES to the question above.

Motor Vehicle Treatment Form

Motor Vehicle Treatment Form

We are very pleased you have chosen our doctors to get you back on the path to wellness after your automobile accident.

It is not our clinic policy to file automobile medical claims on a third-party policy, regardless of which party is at fault. We will be glad to forward your treatment plan and billing to YOUR automobile insurance company. For us to do this it will be necessary to provide us with the following information in order to be seen on your appointment date

Name of your insurance company

Medical claim number you were given when you filed your medical claim with your automobile insurance company *

Name of the person handling your medical claim

First:

Last:

Phone number of the person handling your claim to whom claims and bills will be sent by our clinic *

General information (all applicants)

Major Complaint(s): *Please describe your major complaint(s) and describe the frequency and nature of your pain. For example: dull, sharp, constant, off and on, when standing, when sitting, etc.*

When did your condition first begin and what caused it?

Have you ever had this problem or similar problem before?

- ◯ Yes
- ◯ No

If yes, please explain

Have you seen another chiropractic physician for this complaint?

- ◯ Yes
- ◯ No

If yes, who? *

What was their diagnosis?

Have you seen another medical physician for this complaint?

- ◯ Yes
- ◯ No

If yes, who? *

What treatment have you had for this condition?

What was their diagnosis?

Is your condition getting better, worse, or staying the same?

- ◯ Better
- ◯ Worse
- ◯ Same

What makes your condition worse?

What makes your condition better?

Have you ever been involved in an automobile accident?

- ◯ Yes
- ◯ No

If yes, when and where?

What surgeries have you had? Include Date:

Please list drugs you now take:

Please list vitamins, minerals, supplements, and/or herbs you now take:

Other conditions or additional comments:

Signature of Patient *I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I understand and agree that the health and accident insurance policies are an arrangement between me and my insurance company. I understand that this clinic will file insurance forms to assist me in obtaining payment from the insurance company and that any amount authorized to be paid directly to this clinic will be credited to my account on receipt. I also authorize the release of any needed information. I understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable within 30 days. I also understand that I am giving my consent to be treated. Scheduled appointments that are not kept by the patient with no prior notification of cancellation may be subject to a $25 charge. Returned checks for insufficient funds may be charged $30 per incident.*

Signature of Parent or Guardian *I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I understand and agree that the health and accident insurance policies are an arrangement between me and my insurance company. I understand that this clinic will file insurance forms to assist me in obtaining payment from the insurance company and that any amount authorized to be paid directly to this clinic will be credited to my account on receipt. I also authorize the release of any needed information. I understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable within 30 days. I also understand that I am giving my consent to be treated. Scheduled appointments that are not kept by the patient with no prior notification of cancellation may be subject to a $25 charge. Returned checks for insufficient funds may be charged $30 per incident.*

Insurance Company Name

Provider Customer Service Phone

Member ID Number

Group Number

Secondary Insurance Provider's Information

Insurance Company Name

Provider Customer Service Phone

Member ID Number

Group Number

Family and Social History: Your History

1. Any history of lung disease?

- ◯ Yes
- ◯ No

Explain: *

2. Any history of bowel problems?

- ◯ Yes
- ◯ No

Explain: *

3. Any history of genito/urinary problems?

- ◯ Yes
- ◯ No

Explain:

4. Any history of cardiovascular disease?

- ◯ Yes
- ◯ No

Explain:

5. Any history of neurological diseases?

- ◯ Yes
- ◯ No

Explain: *

6. Any history of cancer?

- ◯ Yes
- ◯ No

Where:

7. Do you use tobacco products?

- ◯ Yes
- ◯ No

How much? *

8. Do you drink alcohol?

- ◯ Yes
- ◯ No

How much?

9. Any history of accident other than automobile?

- ◯ Yes
- ◯ No

Explain

10. Any drug, vitamin or herbal allergies?

- ◯ Yes
- ◯ No

Explain

Family and Social History: Your Family History

1. History of diabetes in your family?

- ◯ Yes
- ◯ No

Explain *

3. History of cancer in your family?

- ◯ Yes
- ◯ No

Explain *

2. History of heart disease in your family?

- ◯ Yes
- ◯ No

Explain

4. History of arthritis in your family?

- ◯ Yes
- ◯ No

Explain *

System Review and Past Medical History *From the following list, please check any symptoms or conditions that apply to you.*

SKIN

- [ ] Rashes, psoriasis or dermatitis
- [ ] History of skin cancer
- [ ] New skin growth or mole
- [ ] None of the above

EYES

- [ ] Wear glasses
- [ ] Wear contact lenses
- [ ] Permanent blindness in either eye
- [ ] Cataracts
- [ ] Glaucoma
- [ ] None of the above

EARS / NOSE / THROAT

- [ ] Loss of hearing
- [ ] Ringing in the ears
- [ ] Discharge from the ear
- [ ] Frequent sinus infections
- [ ] Nasal blockage
- [ ] Frequent sneezing
- [ ] Frequent sore throat
- [ ] Loud snoring
- [ ] Recent change in voice quality
- [ ] Sleep apnea
- [ ] Difficulty in swallowing
- [ ] Frequent headache
- [ ] Nose bleeds
- [ ] Exposure to loud noise
- [ ] None of the above

Hearing Aids?

- ◯ Yes
- ◯ No

STOMACH / INTESTINES

- [ ] Stomach ulcer of peptic ulcer
- [ ] Frequent heartburn or indigestion
- [ ] Hiatal hernia and or acid reflux
- [ ] Poor appetite
- [ ] Gall bladder attacks
- [ ] Frequent diarrhea
- [ ] Chronic constipation
- [ ] Bright blood from bowels or rectum
- [ ] Dark, tarry stools
- [ ] Liver disease or jaundice
- [ ] None of the above

ENDOCRINE / METABOLISM

- [ ] Thyroid disorder
- [ ] Recent weight gain or loss (More than 10 lbs.)
- [ ] Diabetes
- [ ] None of the above

KIDNEYS / URINARY TRACT

- [ ] Kidney disease or failure
- [ ] History of kidney dialysis
- [ ] Kidney stones or infection
- [ ] Pain or burning with urination
- [ ] Trouble starting urinary stream
- [ ] Dribbling or incontinence
- [ ] Multiple trips to the bathroom to urinate at night
- [ ] Bladder infections during past year
- [ ] Blood in urine during past year
- [ ] Prostate disease
- [ ] None of the above

MUSCLES / BONES / JOINTS

- [ ] Arthritis or other joint disease
- [ ] Chronic back trouble
- [ ] Bone or joint surgery in past year
- [ ] None of the above

RESPIRATORY

- [ ] Asthma or wheezing
- [ ] Recent bronchitis or chest cold
- [ ] Cough for over the past 2 months
- [ ] Coughing up blood
- [ ] Shortness of breath
- [ ] None of the above

HEART & CIRCULATION

- [ ] Heart attack
- [ ] Hypertension (high blood pressure)
- [ ] Chest discomfort (angina) with physical activity
- [ ] Heart failure or fluid on the lungs
- [ ] Palpitations, racing or pounding heart beat
- [ ] Stroke
- [ ] Blood clot in artery or vein
- [ ] “Mini-strokes” or TIA’s
- [ ] “Black out spells”
- [ ] Aneurysm of any blood vessel
- [ ] Frequent ankle swelling at bedtime
- [ ] Heart surgery
- [ ] None of the above

NERVOUS SYSTEM

- [ ] Migraine headaches
- [ ] Epilepsy or seizures
- [ ] Depression
- [ ] Other nervous disorder
- [ ] None of the above

Specify your other nervous disorder

Date of last seizure

MM: DD: YYYY:

BLOOD

- [ ] Bleeding or bruising tendency
- [ ] Previous blood transfusion
- [ ] History of hepatitis
- [ ] None of the above

REPRODUCTIVE (Women only) Are you or might you be pregnant?

- ◯ Yes
- ◯ No

Patient Consent for Use and Disclosure Of Protected Health Information

Privacy & Consent Statement

I hereby give my consent for Chi Rho Corrective, P.A. (hereinafter referred to as "CRC") to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO).

CRC Notice of Privacy Practices provides a more complete description of such uses and disclosures. I have the right to review the Notice of Privacy Practices prior to signing this consent. A copy of this Notice is available upon request to Dr. Joshua Witter, Privacy Officers, or any other CRC staff member.

CRC reserves the right to revise its Notice of Privacy Practices at any time and agrees to provide me a revised copy upon my request to CRC.

With this consent, the CRC may call (or text message) my home or other designated phone number on file and leave a message on voice mail or in person in reference to any items that assist CRC in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, CRC may mail to my home or other designated location on file any items that assist CRC in carrying out TPO, such as patient statements.

With this consent, CRC may e-mail to my home or other designated location on file any items that assist CRC in carrying out TPO, such as appointment reminders and patient statements.

I have the right to request that CRC restrict how it uses or discloses my PHI to carry out TPO. However, CRC is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to CRC's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that CRC has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, CRC may decline to provide treatment to me as permitted by Section 164.506 of the Code of Federal Regulations.

Print Patient's Name

First: | Middle: | Last:

Print Name of Legal Guardian, if applicable

First: | Middle: | Last:

Signature

Consent

☐ I have been given and am in receipt of Chi Rho Corrective's Notice of Privacy Practices.

(please initial)

Consent 2

☐ I do not wish to receive a copy of Chi Rho Corrective's Notice of Privacy Practices.

(please initial)

Oswestry Disability Questionnaire

Additional Information

This questionnaire has been designed to give us information as to how your pain is affecting your ability to manage in everyday life. Please answer by checking one option in each section for the statement which best applies to you. We realize you may consider that two or more statements in any one section apply but please just check the box that indicates the statement which most clearly describes your problem.

Section 1: Pain Intensity

- ◯ I have no pain at the moment
- ◯ The pain is very mild at the moment
- ◯ The pain is moderate at the moment
- ◯ The pain is fairly severe at the moment
- ◯ The pain is very severe at the moment
- ◯ The pain is the worst imaginable at the moment

Section 2: Personal Care (e.g.washing, dressing)

- ◯ I can look after myself normally without causing extra pain
- ◯ I can look after myself normally but it causes extra pain
- ◯ It is painful to look after myself and I am slow and careful
- ◯ I need some help but can manage most of my personal care
- ◯ I need help every day in most aspects of self-care
- ◯ I do not get dressed, wash with difficulty and stay in bed

Section 3: Lifting

- ◯ I can lift heavy weights without extra pain
- ◯ I can lift heavy weights but it gives me extra pain
- ◯ Pain prevents me lifting heavy weights off the floor but I can manage if they are conveniently placed, e.g. on a table
- ◯ Pain prevents me lifting heavy weights but I can manage light to medium weights if they are conveniently positioned
- ◯ I can only lift very light weights
- ◯ I cannot lift or carry anything

Section 6: Standing

- ◯ I can stand as long as I want without extra pain
- ◯ I can stand as long as I want but it gives me extra pain
- ◯ Pain prevents me from standing for more than 1 hour
- ◯ Pain prevents me from standing for more than 30 minutes
- ◯ Pain prevents me from standing for more than 10 minutes
- ◯ Pain prevents me from standing at all

Section 7: Sleeping

- ◯ My sleep is never disturbed by pain
- ◯ My sleep is occasionally disturbed by pain
- ◯ Because of pain I have less than 6 hours sleep
- ◯ Because of pain I have less than 4 hours sleep
- ◯ Because of pain I have less than 2 hours sleep
- ◯ Pain prevents me from sleeping at all

Section 8: Sex Life (if applicable)

- ◯ N/A Not applicable
- ◯ My sex life is normal and causes no extra pain
- ◯ My sex life is normal but causes some extra pain
- ◯ My sex life is nearly normal but is very painful
- ◯ My sex life is severely restricted by pain
- ◯ My sex life is nearly absent because of pain
- ◯ Pain prevents any sex life at all

Section 4: Walking

- ◯ Pain does not prevent me walking any distance
- ◯ Pain prevents me from walking more than 1 ¼ miles
- ◯ Pain prevents me from walking more than 2/3 mile
- ◯ Pain prevents me from walking more than 1/3 mile
- ◯ I can only walk using a stick or crutches
- ◯ I am in bed most of the time

Section 5: Sitting

- ◯ I can sit in any chair as long as I like
- ◯ I can only sit in my favorite chair as long as I like
- ◯ Pain prevents me sitting more than one hour
- ◯ Pain prevents me from sitting more than 30 minutes
- ◯ Pain prevents me from sitting more than 10 minutes
- ◯ Pain prevents me from sitting

Signature

Section 9: Social Life

- ◯ My social life is normal and gives me no extra pain
- ◯ My social life is normal but increases the degree of pain
- ◯ Pain has no significant effect on my social life apart from limiting my more energetic interests e.g. sport
- ◯ Pain has restricted my social life and I do not go out as often
- ◯ Pain has restricted my social life to my home
- ◯ I have no social life because of pain

Section 10: Travelling

- ◯ I can travel anywhere without pain
- ◯ I can travel anywhere but it gives me extra pain
- ◯ Pain is bad but I manage journeys over two hours
- ◯ Pain restricts me to journeys of less than one hour
- ◯ Pain restricts me to short necessary journeys under 30 minutes
- ◯ Pain prevents me from travelling except to receive treatment

Today's Date

Privacy & Consent Statement

Consent to Treat Form – Chi Rho Corrective

CHI RHO CORRECTIVE – CONSENT TO CHIROPRACTIC TREATMENT

At Chi Rho Corrective, we are committed to providing quality chiropractic care focused on corrective and wellness-based treatment. Please read the following information carefully and sign below to indicate your understanding and consent.

Nature of Chiropractic Treatment

Chiropractic care involves the science, philosophy, and art of detecting and correcting vertebral subluxations and other musculoskeletal dysfunctions. Techniques may include spinal adjustments/manipulations, soft tissue therapy, rehabilitative exercises, and other supportive modalities.

Potential Benefits

Chiropractic treatment can improve mobility, reduce pain, restore function, and promote overall wellness.

Possible Risks

As with any healthcare procedure, there are potential risks, including but not limited to:

- Temporary soreness or discomfort
- Dizziness or nausea
- Aggravation of underlying conditions
- Rare but serious complications such as stroke (with cervical spine manipulation)

Voluntary Consent

I understand that:

- The doctor will explain the procedures and answer all questions.
- I have the right to refuse or discontinue treatment at any time.
- I am not being coerced into treatment and consent voluntarily.

Acknowledgment

I acknowledge that no guarantee has been made regarding the outcome of my treatment.

Signature of Patient (or Legal Guardian)

Privacy & Consent Statement

HIPAA Consent Form – Chi Rho Corrective

CHI RHO CORRECTIVE – HIPAA PRIVACY CONSENT FORM

To comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Chi Rho Corrective must inform you of your rights and our responsibilities regarding your Protected Health Information (PHI).

Your Rights:

- You have the right to review our **Notice of Privacy Practices** before signing this consent.
- You have the right to request restrictions on how we use and disclose your PHI.
- You may revoke this consent in writing at any time.

Our Responsibilities:

- We will use your PHI for treatment, payment, and healthcare operations.
- We will maintain the privacy of your records as required by law.
- We will provide care whether or not you sign this form, though refusal may limit insurance processing.

Consent:

By signing below, you acknowledge that you:

- Have received and/or reviewed Chi Rho Corrective's **Notice of Privacy Practices** .
- Authorize the use and disclosure of your PHI as described above.

Signature of Patient (or Legal Guardian)