Welcome to Oasis Chiropractic

PID_____

As a full spectrum Chiropractic office, we focus on your ability to be healthy. Our goals are, first, to address the issues that brought you to this office, and second, to offer you the opportunity of improved health potential and wellness services in the future. On a daily basis we experience many types of stress (Physical, Mental, and Chemical) that can interfere with your spine and nervous system. Spinal health is an exciting new concept for many people. So please remember to ask questions.

Please take a moment to answer the following questions that are designed to maximize your health.

Name: Date: SEX: M / F – Are you pregnant? Y/N?
Who may we "Thank" for referring you?
Address: Apt# City/State/Zip:
Email Address:
Home Phone: Work Phone: Cell Phone:
Birth Date:
Marital Status: Married Widow Divorce Single
Your Employer: Occupation:
Spouse's Name: Spouse's Employer:
Children's Names and Ages:
Method of Payment for First Visit: Cash Check Credit Card Already Paid / Gift Certificate
I have a Flex Plan or Medical Savings account that I will need a receipt for Yes or No

Why did you decide to come to office now: ____?

____

Are you currently benefiting from chiropractic? Y / N
Have you ever been to a chiropractor before? Y / N
Name of Dr. ______________ First Visit__________ Last Visit___________________
Has any other member of your family been to a chiropractor before? Y / N
Was their experience? Excellent Average poor don't know

On a Scale of 1-10 (1 = none 10 = Extreme) How committed to your health are you? _____
How committed to your health do you want the doctor to be? _____

On the scale of 1-10 describe your stress level (1 = none 10 = Extreme)
Occupational______________ Personal ________________

On a Scale of Poor, Fair, Good, or Excellent describe your:
Diet____________ Exercise____________ Sleep__________ General Health__________

What have you done in the past to improve your health potential? (please circle all that apply)
Aerobic Exercise, Weight Training, Nutrition Supplements, Stretching Program/Yoga, Acupuncture, Massage, Corrective Chiropractic, Wellness Chiropractic, Eating Right/Diet Program, Self Education on Health Information

Are you aware that:

The brain and nervous system control all functions of the body?	Y / N
Your brain and organs communicate with each other by sending signals on nerves?	Y / N
The nerves branch off from your spinal cord, between the bones in your back?	Y / N
When the spine bones are out of alignment, they cause interference to the nerves?	Y / N
Interference to the nerves changes how your organs, and muscles function?	Y / N
Chiropractors locate and remove interference to the nerves so your body can function?	Y / N
Research states, that for optimum health, your spine should be maintained from birth?	Y / N

ADDRESSING THE ISSUES THAT BROUGHT YOU TO THE OFFICE

If you have no symptoms or complaints, and are here for wellness services, check here ____
And proceed to the ***Health History*** portion. If you are experiencing any symptoms please mark the chart below and answer the following questions

Please mark **area(s)** of injury or discomfort as shown in the example below. Mark all areas with the appropriate symbols and indicate the degree of pain using a scale from 1 (discomfort) to 10 (extreme pain).

Description →	Numbness	Pins & Needles	Burning	Aching	Stabbing
Symbol →	NNNN	PPPP	BBBB	AAAA	SSSS

⬭ Circle any area of pain not represented by a symbol.

AAAA 4
Example
SSSS 7
Example

right left left right

Right Front Back Left

When did the problem start giving you symptoms____________________________
Since the problem started, is it? Better Worse About the Same
If you are experiencing pain, is it? Sharp Dull Travels Comes and Goes Constant
What makes your problem worse____
This problem interferes with: Work School Sleep Walking Sitting Hobbies
This condition is related to an: automobile accident / a work injury / Does not apply
Any other accidents, falls, slips, in the past? ____
Have you previously experienced this type of condition? Y/N when:_____________________
Other Doctors seen for this problem (please list)
Chiropractor___________________Medical Doctor________________ Physical Therapist____________

Health History (Research shows that many of our health problems are from things we are currently doing, or have done.)
Ht______ Wt______ Blood Pressure_____/_______ Respiration Rate _______ Resting Heart Rate_______
Do/Did you ever have pain that wakes you up at night? Y / N
Do/Did you ever take corticosteroids for a chronic condition? Y / N
Have you ever experienced any unintentional weight loss? Y / N
Do you ever have fever, chills, or night sweats? Y / N
Do you have a loss of bowel/ bladder control? Y / N
Have you ever been diagnosed with Cancer, AIDS, or immune system abnormalities? ` Y / N
Do/Did you smoke? Y / N Did you have any serious falls as a child? Y / N
Have you ever been in any accidents? Y / N As a child were you under chiropractic care? Y / N
Do you have scoliosis? Y / N Do/Did you play any sports (school/recreation)? Y / N
Please list any surgeries that you have had
____
Please list any medications you are taking and what the medication is for. (Example: Tums for heartburn)
____

Family History of Illnesses?____

As a result my chiropractic care, I would like to: (circle all that apply)

Reduce pain | Improve my level of overall health | Have a healthier spine
Prevent any future problems | Correct the cause of my problem | Live a healthier lifestyle

Spinal Nerve Function

The following symptoms may be caused by subluxations of the spine. Look at the vertebral level on the left and indicate if you have had any of the symptoms over the last 3 months.

0- Never 1- Monthly 2- Weekly 3- Daily

Symptoms	Frequency	Symptoms	Frequency
Cervical Spine			
Headaches	0 1 2 3	High Blood Pressure	0 1 2 3
Earaches	0 1 2 3	Memory Loss	0 1 2 3
Hearing Loss	0 1 2 3	Allergies	0 1 2 3
Sore Throat	0 1 2 3	Blurred Vision	0 1 2 3
Sinus Problems	0 1 2 3	Stuffy Nose	0 1 2 3
Watery/Itchy Eyes	0 1 2 3	TMJ Problem	0 1 2 3
Lazy/Crossed Eyes	0 1 2 3	Canker Sores	0 1 2 3
Carpal Tunnel	0 1 2 3	Colds/Flu	0 1 2 3
Thyroid Problems	0 1 2 3	Cold hands/Feet	0 1 2 3
Excessive Swelling	0 1 2 3	Numbness in Arms	0 1 2 3
Thoracic Spine			
Heart Conditions	0 1 2 3	Pleurisy	0 1 2 3
Asthma	0 1 2 3	Chronic Cough	0 1 2 3
Bronchitis	0 1 2 3	Short of Breath	0 1 2 3
Indigestion	0 1 2 3	Chest Pain	0 1 2 3
Nausea	0 1 2 3	Poor Circulation	0 1 2 3
Reflux	0 1 2 3	Intestinal Pain	0 1 2 3
Stomach Pain	0 1 2 3	Diabetes	0 1 2 3
Ulcers	0 1 2 3	Hypoglycemia	0 1 2 3
Crave Sweets	0 1 2 3	Anxiety	0 1 2 3
Heartburn	0 1 2 3	Depression	0 1 2 3
Insomnia	0 1 2 3	Hyper Activity	0 1 2 3
Fatigue	0 1 2 3	Gassy	0 1 2 3
Irritable Bowel	0 1 2 3	Bloating	0 1 2 3
Skin Irritations	0 1 2 3	Weight Gain	0 1 2 3
Acne	0 1 2 3	Water Retention	0 1 2 3
Lumbar Spine			
Constipation	0 1 2 3	Irregular Periods	0 1 2 3
Diarrhea	0 1 2 3	Hot Flashes	0 1 2 3
Bladder Infection	0 1 2 3	Infertility	0 1 2 3
Bed Wetting	0 1 2 3	Numbness in Legs	0 1 2 3
Frequent Urination	0 1 2 3	Sciatic Pain	0 1 2 3
Yeast Infection	0 1 2 3	Sprained Ankles	0 1 2 3
PMS	0 1 2 3	Knee Pain	0 1 2 3
All Joints			
Aches in Muscles	0 1 2 3	Lethargy	0 1 2 3
Joint Pain	0 1 2 3	Restlessness	0 1 2 3
Arthritis	0 1 2 3	Weakness	0 1 2 3
Stiffness	0 1 2 3		

HIPPA Privacy Policies for Chiropractic Care

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working toward the same objective. It is important that each patient understand both the objective and the method that will be used to attain this objective. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks and alternatives.

Information: **Chiropractic** is a science and art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may effect the restoration and preservation of health. **Health** is a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

One disturbance to the nervous system is called a vertebral **subluxation**. This occurs when one or more of the 24 vertebra in the spinal column become misaligned and/or do not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by an **adjustment**. An adjustment is the specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine. Adjustments are usually done by hand but may be performed by handheld instruments. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included.

If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider. You may request a copy of your information be sent to another provider, but all requests must be in writing and must include a signature.

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

HIPPA PRIVACY POLICIES

The privacy of your health information is important to us. It is our legal duty to maintain the privacy of your health information. We offer you the ability to review the notice about our privacy practices, our legal duties, and your rights concerning your health information at any time. Our privacy policy can also be viewed at any time on the wall by the front door.

I authorize the release of any medical or other information necessary to process an insurance claim.
I authorize payment of medical benefits to be paid to Oasis Chiropractic P.A. for services provided.
I have had the opportunity to review the HIPPA privacy policies as stated above.

Name of Patient:____
Signature of Patient:_________________________Date:_____________________

Name Printed of Guardian/Parental and Relationship to Patient:_________________
Guardian/Parental Signature:_____________________ Date:_____________________

CHIROPRACTIC INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of chiropractic procedures, including various modes of physio therapy, diagnostic x-rays, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic indicated below and/or other licensed doctors of chiropractic and support staff who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and procedures.

I understand and I am informed that, as is with all Healthcare treatments, results are not guaranteed and there is no promise to cure. I further understand and I am informed that, as is with all Healthcare treatments, in the practice of chiropractic there are some risks to treatment, including, but not limited to, muscle spasms for short periods of time, aggravating and/or temporary increase in symptoms, lack in improvement of symptoms, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I further understand that Chiropractic adjustments and supportive treatment is designed to reduce and/or correct subluxations allowing the body to return to improved health. It can also alleviate certain symptoms through a conservative approach with hopes to avoid more invasive procedures. However, like all other health modalities, results are not guaranteed and there is no promise to cure. Accordingly, I understand that all payment(s) for treatment(s) are final and no refunds will be issued. However, prorated fees for unused, prepaid treatments will be refunded if I wish to cancel the treatment.

I further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include, but not limited self-administered, over the counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; physical therapy; steroid injections; bracing; and surgery. I understand and have been informed that I have the right to a second opinion and secure other opinions if I have concerns as to the nature of my symptoms and treatment options.
I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Name of Patient:____

Signature of Patient:________________________________Date:_________________________

Name Printed of Guardian/Parental and Relationship to Patient: __________________________

Guardian/Parental Signature: __________________________Date:_________________________

Doctor of Chiropractic Name: ____

Signature of Doctor of Chiropractic: ______________________________Date:__________________