A.Nickel Chiropractic
Alexandrea Nickel D.C.

Application for Care

Date: _____

Patient Demographics

Name: _____ DOB: _____/_____/_____ Age: _____ ☐ M ☐ F ☐Other

Street: _____ City: _____ State: _____ Zip: _____

Email: _____ Phone # : _____

Marital Status: M S D W # of children: _____ SSN _____

Occupation: _____ Primary Care Physician: _____

Insurance Information Do you have insurance? ☐ Yes ☐ No

Name of Primary Insurance: _____ Subscribers Name: _____D.O.B_____

Name of Second Insurance: _____ Subscribers Name: _____D.O.B._____

In Case of Emergency Name & Phone Number:_____

History of Complaint

Is the issue the result of a: ☐ Car Accident ☐ Work Injury Date of Injury: _____

Rate your pain level at its **WORST**

Major Complaint: _____ **No Pain 0- 1–2-3-4-5-6-7-8-9-10 Worst Pain**

Other complaint: _____ **No Pain 0- 1–2-3-4-5-6-7-8-9-10 Worst Pain**

How long have you had this issue? _____

What makes your condition better? _____worse? _____

How long does it last? ☐Constant ☐ On/off --☐ 25% of day ☐ 25-50% of day ☐ 50-75% of day ☐75-100% of day

Have you been to a chiropractor before? ☐ No ☐ Yes Have you ever had x-rays? _____

Are you taking any medications? ____ Name and dose?_____

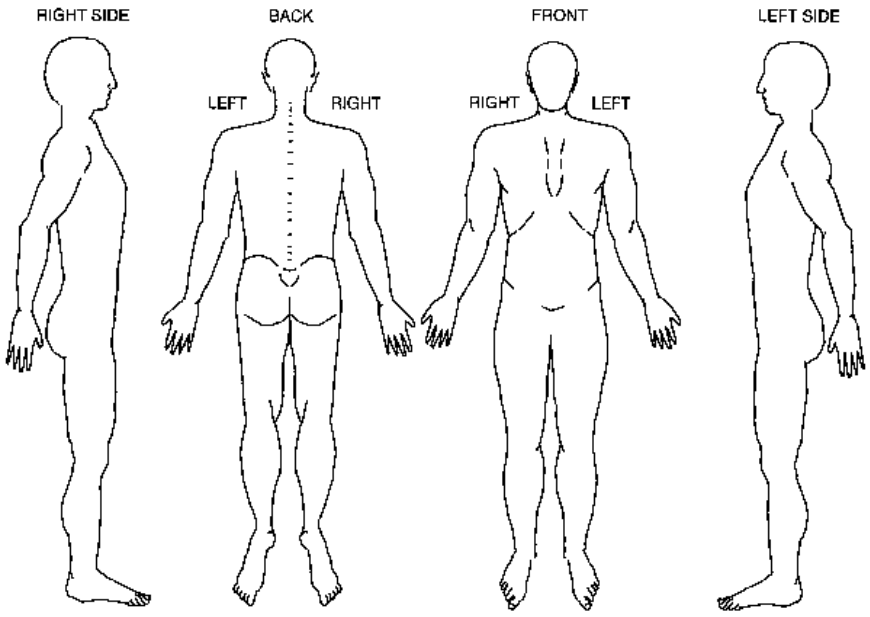
Other forms of treatment tried? ☐ No ☐ Yes If Yes, what type of treatment? _____

What were the results ☐ favorable? ☐ unfavorable?

Put an X where ALL of your pain/ sensations are and label what it feels like

Does the pain travel? _____ Where does it travel? Show where the pain travels below

A=Aching
B=-Burning
St=Stabbing
D=Dull
N=Numbness
P=Pins and needles
DP=Deep



Patient/ Parent or Guardian Signature: _____Date: _____

PAST HISTORY

Select if you currently have or have ever been diagnosed with any of the following conditions:

_____arthritis/bursitis _____ angina _____arrhythmia _____bypass _____ cancer _____ cystic fibrosis
_____diabetes _____ diverticulosis _____ emphysema _____ fibromyalgia _____gout _____hypertension
_____heart attack /disease / failure _____ kidney stones ____high cholesterol _____pacemaker
_____kidney issue _____leg swelling _____liver problems _____murmur _____ pneumonia _____reflux
_____ Rheumatoid arthritis _____sleep apnea _____ stroke _____thyroid issue_____ tuberculosis
_____whiplash _____sprains _____HIV _____Paget's disease _____ Varicose Veins _____ tumors_____ ulcer
_____ Muscular dystrophy _____multiple sclerosis _____broken bones in the last 2 years _____ dislocations
_____accidents (last 2 years) _____ osteoarthritis
_____ Allergies (_____ food _____ seasonal _____ Other: _____)
_____Surgery: Where?/When? _____

SOCIAL HISTORY

Smoking: ☐ Cigars ☐ Pipe ☐ Cigarette ☐ E -cigarette/Vape
How much_____ How often? ☐ Daily ☐ Weekends ☐ occasionally ☐ never
Alcoholic Beverages: How much _____ How often? ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never
Recreational drugs :_____ How often? ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never
How well do you sleep? ☐ Good ☐ Fair ☐ Poor Interruptions ? ☐ Yes ☐ No How many times/night?_____

FAMILY HISTORY Does anyone in your family suffer with these conditions? Check if applicable.

_____ angina _____arrhythmia _____bypass _____ cancer _____ cystic fibrosis _____diabetes_____ dialysis
_____ diverticulosis _____ emphysema _____ fibromyalgia _____gout _____hypertension _____murmur
_____heart attack/ disease/ failure _____hemophilia _____ kidney stone _____ Varicose Veins
____high cholesterol _____kidney issue _____liver issues _____ obesity _____pacemaker ____Rheumatoid arthritis
_____sleep apnea _____ stroke _____thyroid issue _____ tuberculosis _____Paget's disease _____ ulcer
_____ Muscular dystrophy _____multiple sclerosis_____ tumors
_____ Allergies (_____ food _____ seasonal _____other:_____)
_____ Other unlisted conditions: _____

ACTIVITY OF DAILY LIVING Explain how your condition is affecting your ability to perform activities

1. Carrying weight? ☐ No effect ☐ Painful (Can do) ☐ Painful (limits) ☐ Can't perform
2. Sitting to Standing ☐ No effect ☐ Painful (Can do) ☐ Painful (limits) ☐ Can't perform
3. Climbing stairs? ☐ No effect ☐ Painful (Can do) ☐ Painful (limits) ☐ Can't perform
4. Computer/ Phone use? ☐ No effect ☐ Painful (Can do) ☐ Painful (limits) ☐ Can't perform
5. Reading? ☐ No effect ☐ Painful (Can do) ☐ Painful (limits) ☐ Can't perform
6. Getting dressed? ☐ No effect ☐ Painful (Can do) ☐ Painful (limits) ☐ Can't perform
7. Sexual activities? ☐ No effect ☐ Painful (Can do) ☐ Painful (limits) ☐ Can't perform
8. Sleep? ☐ No effect ☐ Painful (Can do) ☐ Painful (limits) ☐ Can't perform
9. Sitting? ☐ No effect ☐ Painful (Can do) ☐ Painful (limits) ☐ Can't perform
10. Yard work? ☐ No effect ☐ Painful (Can do) ☐ Painful (limits) ☐ Can't perform
11. Walking? ☐ No effect ☐ Painful (Can do) ☐ Painful (limits) ☐ Can't perform
12. Washing/Bathing/ Hygiene? ☐ No effect ☐ Painful (Can do) ☐ Painful (limits) ☐ Can't perform
13. House chores? ☐ No effect ☐ Painful (Can do) ☐ Painful (limits) ☐ Can't perform
14. Driving? ☐ No effect ☐ Painful (Can do) ☐ Painful (limits) ☐ Can't perform
15. Hobbies? ☐ No effect ☐ Painful (Can do) ☐ Painful (limits) ☐ Can't perform
16. Other? _____ ☐ No effect ☐ Painful (Can do) ☐ Painful (limits) ☐ Can't perform

These statements made on this form are accurate to the best of my recollection and I agree to allow **A. Nickel Chiropractic** to examine me for further evaluation. _____ **Initials**

Patient/ Parent or Guardian Signature: _____Date: _____

Informed Consent to Chiropractic Care

Informed Consent

You are the decision maker for your health care. Our role is to provide you with information to assist you in making informed choices. This informed consent involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with care, alternatives, and the potential effect on your health if you choose not to receive the care.

The Nature and Purpose of Chiropractic

Chiropractic is predicated on the science with the relationship between structures (primarily the spine) and function (primarily of the nervous system) of the body and how this relationship can affect the restoration and preservation of health. The following information is routinely furnished to all who consider chiropractic care and treatment in this office.

A chiropractic examination will be undergone which include spinal and physical examination orthopedic and basic neurological testing, specialized instrumentation, and possibly radiological examination (x-rays). We may conduct some diagnostic or examination procedures not indicated. Any examination or test conducted will be carefully performed but may be uncomfortable.

Chiropractic care involves a chiropractic adjustment. The chiropractic adjustment is the application of a precise, high velocity movement of the spine, over a short distance to correct spinal and extremity joint subluxation. One of the most common disturbances to the nervous system is the **vertebral subluxation.** This condition is one where one or more vertebra in the spine is misaligned sufficiently to cause interference and irritation to the nervous system. The primary goal in chiropractic health care is the removal of nerve interference caused by subluxation.

There are several different methods or techniques which the chiropractic adjustment is delivered. Chiropractic adjustments are typically delivered by hand, but some may require the use of an instrument or specialized equipment to reposition anatomical structures. In addition, physiotherapy or rehabilitative procedures may be included in the management protocol.

The benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint and improving neurological functioning and overall well-being. One should also be aware of the existence of risks and limitations of this care. It is important that you understand, as with all healthcare approaches, results are not guaranteed, and there is no promise to cure.

Treatment modalities

Chiropractic care centrally involves what is known as a chiropractic adjustment. There will most likely be additionally supportive procedures or recommendations as well. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being. The procedures depend upon your specific circumstance and may include but are not limited to: ultrasound, hot packs, electrical stimulation, laser, traction, exercises and other physical modalities.

Risks and benefits

It is important that you understand **results are not guaranteed, and there is no promise to cure. As with all types of healthcare interventions,** there are some risks to care, including but not limited to: **muscle spasms, aggravating / temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation, hot or cold therapies, including hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains and sprains.** The risks are seldom high enough to contraindicate care but should be considered when making the decision to seek chiropractic care.

As with all types of healthcare interventions there are risks, including but not limited to: muscle spasms, injuries, dislocations, musculoskeletal strains, ligament sprains, neurological injury Vertebral Artery Syndrome (VAS) including stroke and perhaps death through complicating factors. Risks associated with physiotherapy may include allergic reaction, muscle and or joint pains, burn and or scarring from hot and cold therapies. Some patients will experience stiffness and soreness following the first few days after treatment. Some types of manipulations of the neck have been associated with injuries to the arteries in the following few days after treatment. The doctor will make every reasonable effort to screen for contraindications to care, however if you have a condition that would otherwise not come to the doctors' attention, it is YOUR responsibility to inform the doctor.

Patient/ Parent or Guardian Signature: _____Date: _____

Probability of risk occurrence

Fractures are rare occurrences and generally result from some underlying weakness of the bone which we check for during the history taking, exam and via x-rays. Stroke of vertebral artery dissection caused by chiropractic manipulation of the neck has been the ongoing, medical research and debate. The most current research on the topic is inconclusive as to a specific incident of this complication occurring. If there is a causal relationship at all, it is extremely rare and remote. Unfortunately, there is no recognized, safe screening procedure to identify patients with neck pain who are at risk for vertebral artery dissection and stroke.

Risks and dangers of remaining untreated

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction, further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

Alternative treatment options

It is important that you understand there are more treatment available for condition other than chiropractic procedures. You have tried many of these approaches already. These options may include, but not limited to: self-administered care, over the counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, surgery or no care at all. Lastly, you have the right to a second opinion about your circumstances and health care as you see fit.

Analysis/examination/ treatment

As part of the analysis, exam and treatment, you are consenting to the following procedures:

Chiropractic adjustment spinal manipulative therapy, light and deep palpation, vital signs, range of motion study, orthopedic testing, basic neurology, muscle strength testing, postural analysis testing, heat cryotherapy, muscle stimulation/ EMS, and assisted rehabilitative exercises.

Patient acknowledgement

- I have read the above consent and I understand the information provided.
- I have had an opportunity to ask questions about its content and all question.
- I have about this information have been answered to my satisfaction.
- I have been informed of the nature and purpose of chiropractic care, the possible consequences of care, and the risks of care, including the risk that the care may not accomplice-shed the desired objective.
- I have been told alternative treatments have been explained, including the risks, consequences, and probable effectiveness of each.
- I have been advised of the possible consequences if no care is received.
- I acknowledge that no guarantees have been made to me concerning the results of the care and treatment.
- I appreciate that it is not possible to consider every possible complication to care and by signing below
- I agree with the current or future recommendations to receive chiropractic care as is deemed appropriate for my circumstance.
- I intend this consent to cover the entire course of care for my present condition and for any future conditions for which I seek chiropractic care from this office.

By signing below, I acknowledge receipt of this office's **Informed Consent**, provided on my behalf and in accordance with the law, and have read and understand the tactics regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you chose not to receive the care as a client of this practice. I was given the opportunity to read and ask questions.

Patient/ Parent or Guardian Signature: _____Date: _____

Assignment of benefits/ Lien assignment/Release of information

Assignment of Benefits

- I authorize payment to be made directly to, **A. Nickel Chiropractic**, for all benefits which may be payable under a healthcare plan or from any other collateral sources.
- I authorize use of this applications for processing claims and effecting payments.
- I acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to **A. Nickel Chiropractic** for any/all serviced I receive at this office.
- I agree to pay for services at time services are rendered unless other financial arrangements have been made with **A. Nickel Chiropractic.**
- I agree to assign to **A. Nickel Chiropractic,** the benefits under my insurance policies for other reimbursement source.
- I recognize and accept responsibility for any balance remaining after payment of benefits. I acknowledge that any balance not covered or paid by such policy/ plan is my legal responsibility.
- I understand I am financially responsible for all charges whether paid by insurance or settlement.
- I agree to pay all charges unless credit arrangements are agreed upon in writing.
- I authorize **A. Nickel Chiropractic** to release all information necessary to secure the payments of benefits.
- I authorize the use of my signature on all my insurance submissions.
- I authorize benefits to be paid directly to the physician.
- I understand that I am responsible for any balance**.**

Lien Assignment- *If you're in need of treatment due to an accident, the office will work with your insurance and attorney to collect fees from responsible party's or the party's insurance company.*

- I, the injured party, agree to be responsible for all charges with **A. Nickel Chiropractic.** _____ **Initials**
- I agree to assign the designated portion of any settlement for judgement obtained in a lawsuit from the responsible party to **A. Nickel Chiropractic**. _____ **Initials**

Release of Information

- I authorize **A. Nickel Chiropractic** to release/obtain any information in my financial or medical records during my examination or treatment to/from my insurance company and its representatives and agents, health facilities with a written consent or any other person/entity affiliated with **A. Nickel Chiropractic** for the purposes of administration, billing, and collection. _____ **Initials**
- I authorize **A. Nickel Chiropractic** or my insurance company to release any information required to process my claim. _____ **Initials**
- I understand this consent applies to all records created during and related to my care with **A. Nickel Chiropractic**. _____ **Initials**

By signing below, I acknowledge receipt of this office's **Assignment of benefits/ Lien assignment/Release of information**, provided on my behalf and in accordance with the law, and I was given the opportunity to read and ask questions.

Patient/ Parent or Guardian Signature: _____Date: _____

HIPAA Privacy Authorization Form.- Authorization for Use & Disclosure of Protected Health Information

(Required by the Health Insurance Portability and Accountability Act- 45 CFR Part 160-164)

- I understand that my treatment, payment, enrollment, or eligibility for benefits will not be affected by my signing or not signing this release.
- I authorize **A. Nickel Chiropractic** to **use/ disclose** the protected health information described below for treatment and care.

  (Please Select Option A or B)

  A. I authorize the release of my complete health record.
  B. I DO NOT authorize the release of my complete health record.
  C. Do not discuss/release my medical records or private health information to anyone (including family members) or any entity.
    - This option is not available to patients under the age 18, although we must have written documentation indicating the adult with whom we will discuss care. _____ **Initials**
- I authorize **A. Nickel Chiropractic** to **release** all information to the following person.

  Name: _____ Relationship: _____
- This authorization shall be in force until revoked by me, (Pt name)_____.
- To revoke authorization, I will submit a Notice of Revocation in writing**.**
- I understand that I have the right to revoke this authorization at any time.
- I understand that a revocation is not effective in that any entity that has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has legal right to contest a claim.
- **A. Nickel Chiropractic** and its employees are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

By signing below, I acknowledge receipt of this office's **HIPAA Privacy Authorization Form.- Authorization for Use & Disclosure of Protected Health Information**, provided on my behalf and in accordance with the law, and have read and understand my rights to privacy and security of Personal Health Information, as a client of this practice. I was given the opportunity to read and ask questions.

Patient/ Parent or Guardian Signature: _____Date: _____