Who may we thank for referring you into this office? _____

RELENTLESS
CHIROPRACTIC

**Today's Date:** _____ **HRN:** _____

## PATIENT DEMOGRAPHICS

Name: _____ Birth Date: ____-____-____ Age: _____ ☐ Male ☐ Female

Address: _____ City: _____ State: _____ Zip: _____

E-mail Address: _____ Home Phone: _____ Mobile Phone: _____

Marital Status: ☐ Single ☐ Married Do you have insurance: ☐ Yes ☐ No Work Phone: _____

Employer: _____ Occupation: _____

Spouse's Name: _____ Spouse's Employer: _____

Number of Children and Ages: _____

Emergency Contact Name: _____ Number: _____ Relationship: _____

## HISTORY OF COMPLAINT

**Please identify** the condition(s) that brought you to this office, on a scale of **0** to **10** with **10** being the worst pain and **0** being no pain; rate your complaint by **circling the number**.

**Primary Complaint**: _____ **Scale** 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

**Secondary Complaint**: _____ **Scale** 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

**Third Complaint**: _____ **Scale** 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

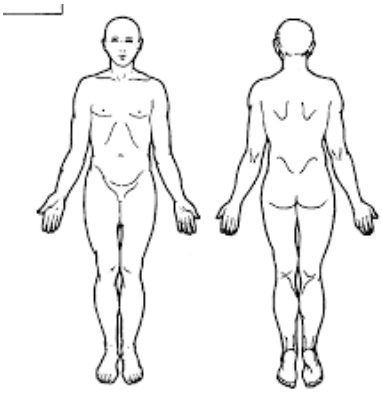
When did the problem begin? _____ When is the problem at its worst? ☐ AM ☐ PM ☐ Mid-Day ☐ Late PM

How long does it last? ☐ It is constant ☐ I experience it on and off during the day ☐ it comes and goes throughout the week

Condition(s) ever been treated by anyone in the past? ☐ No ☐ Yes If yes, When: _____ by Whom: _____

**PLEASE MARK** the areas on the diagram with the following letters to describe your symptoms:

**R**: **R**adiating **B**: **B**urning **D**: **D**ull **A**: **A**ching **N**: **N**umbness **S**: **S**harp/**S**tabbing **T**: **T**ingling



What relieves your symptoms? _____

What makes your symptoms feel worse? _____

Is your problem the result of ANY type of accident/injury? ☐ Yes ☐ No

Explain: _____

Identify any other injury(s) to your spine, minor or major, that the doctor should know about: _____

Have you suffered with any of this or a similar problem in the past ☐ Yes ☐ No

If yes, explain: _____

## PAIN SCALE

Patient Name: _____ Date: _____

**Please Read Carefully:**

Instructions: Please circle the number that best describe the question being asked.
**0 – Being NO Pain and 10 – Worst Possible Pain**

1. What is your pain **RIGHT NOW**?

No Pain _____ Worst Possible Pain

0 1 2 3 4 5 6 7 8 9 10

2. What is your **TYPICAL** or **AVERAGE** pain?

No Pain _____ Worst Possible Pain

0 1 2 3 4 5 6 7 8 9 10

3. What is your pain level **AT ITS BEST** (How close to "0" does your pain get at its best)?

No Pain _____ Worst Possible Pain

0 1 2 3 4 5 6 7 8 9 10

4. What is your pain level **AT ITS WORSE** (How close to "10" does your pain get at its worst)?

No Pain _____ Worst Possible Pain

0 1 2 3 4 5 6 7 8 9 10

Other Comments:

_____

_____

**PAST HISTORY**

Have you been to a chiropractor in the last 5 years? ☐ Yes ☐ No

Have you tried other forms of treatment? ☐ Yes ☐ No **If yes**, explain type of treatment: _____

Please identify any and all types of jobs you have had in the past that have imposed any physical stress on you or your body?

_____

Have you had any major surgeries? ☐ Yes ☐ No If yes, Explain: _____

If you have ever been diagnosed with any of the following conditions, **PLEASE INDICATE** which ones apply to you:

| List | Past | Current | List | Past | Current |
|---|---|---|---|---|---|
| ADD/ADHD | ☐ | ☐ | Irritable | ☐ | ☐ |
| Allergies | ☐ | ☐ | Impotence/Sexual Dysfun. | ☐ | ☐ |
| Asthma | ☐ | ☐ | Jaw Pain, TMJ | ☐ | ☐ |
| Back Curvature | ☐ | ☐ | Kidney Trouble | ☐ | ☐ |
| Bed Wetting | ☐ | ☐ | Learning Disability | ☐ | ☐ |
| Blood Disorder | ☐ | ☐ | Liver Trouble | ☐ | ☐ |
| Blood Pressure (high/low) | ☐ | ☐ | Loss of Balance | ☐ | ☐ |
| Blurred Vision | ☐ | ☐ | Low Back Pain | ☐ | ☐ |
| Broken Bone | ☐ | ☐ | Lung Problems | ☐ | ☐ |
| Cancer | ☐ | ☐ | Menopausal Problems | ☐ | ☐ |
| Cerebral Vascular | ☐ | ☐ | Menstrual Problem | ☐ | ☐ |
| Chest Pain | ☐ | ☐ | Mid Back Pain | ☐ | ☐ |
| Colon Trouble | ☐ | ☐ | Mood Changes | ☐ | ☐ |
| Convulsions/Epilepsy | ☐ | ☐ | Neck Pain | ☐ | ☐ |
| Depression | ☐ | ☐ | Numb/Tingling | ☐ | ☐ |
| Diabetes | ☐ | ☐ | (arms, hands, fingers) | ☐ | ☐ |
| Diarrhea/Constipation | ☐ | ☐ | Numb/Tingling | ☐ | ☐ |
| Difficulty Breathing | ☐ | ☐ | (legs, feet, toes) | ☐ | ☐ |
| Digestive Problems | ☐ | ☐ | Osteo Arthritis | ☐ | ☐ |
| Disability | ☐ | ☐ | Pain with Sneeze/Cough | ☐ | ☐ |
| Dislocations | ☐ | ☐ | PMS | ☐ | ☐ |
| Dizziness | ☐ | ☐ | Pregnant (none) | ☐ | ☐ |
| Double Vision | ☐ | ☐ | Prostate Problems | ☐ | ☐ |
| Fainting | ☐ | ☐ | Rheumatoid Arthritis | ☐ | ☐ |
| Foot/Knee Problems | ☐ | ☐ | Ringing in ears | ☐ | ☐ |
| Fracture | ☐ | ☐ | Scoliosis | ☐ | ☐ |
| Frequent Colds/Flu | ☐ | ☐ | Shoulder Pain | ☐ | ☐ |
| Gall Bladder Trouble | ☐ | ☐ | Sinus/Drainage Problems | ☐ | ☐ |
| Headache | ☐ | ☐ | Skin Problems | ☐ | ☐ |
| Hearing Loss | ☐ | ☐ | Swollen/Painful Joints | ☐ | ☐ |
| Heart Attack | ☐ | ☐ | Tremors | ☐ | ☐ |
| Heartburn | ☐ | ☐ | Trouble Sleeping | ☐ | ☐ |
| Heart Problems | ☐ | ☐ | Tumors | ☐ | ☐ |
| Hepatitis (A,B,C) | ☐ | ☐ | Ulcers | ☐ | ☐ |
| Hip Pain | ☐ | ☐ | Upper Back Pain | ☐ | ☐ |

## SOCIAL HISTORY

**Smoking:** ☐ Cigars ☐ Pipe ☐ Cigarettes How often? ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never

**Alcoholic Beverage:** Consumption occurs: ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never

**Recreational Drug Use:** ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never

## FAMILY HISTORY

Does anyone in your family suffer with the same condition(s)? ☐ Yes ☐ No If yes, whom: _____

Have you ever been treated for their condition: ☐ Yes ☐ No ☐ I don't know

Any other hereditary conditions the doctor should be aware of? ☐ Yes ☐ No If Yes, Explain: _____

## FINANCIAL AGREEMENT

Our experience has shown that it is wise to have an understanding with our patients as to our office policy and fees. Therefore, this form has been prepared for your convenience and information. As an office policy, we will discuss your treatment plan and all expected financial obligations **before** beginning corrective care in our office so that you can make an informed decision about your health.

There are several cost effective ways to receive care in our office and each will be discussed with you before beginning any corrective careplan. If at any time your insurance coverage or financial situation changes, it will be your responsibility to contact our billing department for updates.

As always, our main concern is your **health** and **well-being,** and we will work with you to provide that care in a way that is most appropriate for you.

**Plan 1: Insurance**

If you have insurance which covers chiropractic services, we will bill your insurance company directly. However, you are responsible for the portion which your policy may not cover. For example:

A. Most insurance plans have a deductible that must be satisfied before the plan is effective.

B. Most insurance plans provide co-insurance for your chiropractic care, meaning, for example, they will account for 80% of your acute care and you will be responsible for the remaining 20%.

C. Most insurance companies are only concerned with sick-care and do not cover wellness or maintenance visits.

A financial estimate will be completed and reviewed with you before a corrective careplan begins.

**Plan 2: Cash**

This plan means that all fees will be paid by the patient. Cost effective payment plan options will be discussed with our office before any treatment plan is started.

**Plan 3: Personal Injury**

If you are in an auto accident or in any type of personal injury suit, we will render care and send the bill to your attorney or authorized insurance carrier. If an attorney is involved, an attorney's lien must be signed to direct payment of the bill.

The patient and attorney must keep our office up-to-date as to any changes or conditions in this case. If an insurance company is billed, benefits must be assigned to the doctor and an insurance form must be provided.

NO CHARGES WILL BE INCURRED IN OUR OFFICE WITHOUT PRIOR CONSENT FROM THE PATIENT. IF YOU EVER FEEL A CHARGE HAS BEEN MADE IN ERROR, PLEASE CONTACT OUR OFFICE IMMEDIATELY. YOU ARE ONLY RESPONSIBLE FOR SERVICES RENDERED.

I INTEND TO USE PLAN #_____ FOR THE CHIROPRACTIC CARE WHICH I NEED.

**If for any reason the recommended chiropractic care is not completed, this agreement will apply only to the services actually completed and in no way obligates me to continue the course of treatment recommended. If care is discontinued, the balance due for care received up to that date is due in full within 30 days.**

**I agree to pay all costs of collection including reasonable attorney fees where collection is turned over to an attorney for collection. I hereby waive all rights of exemptions under the constitution and laws of the State of Alabama and the United States of America.**

_____ _____ - _____ - _____
Patient or Authorized Person's Signature Date Completed

_____ _____ - _____ - _____
Doctor's Signature Date Reviewed

Patient's Name: _____ HR#:_____ Date:_____

RELENTLESS
CHIROPRACTIC

# Informed Consent

## REGARDING: Chiropractic Adjustments, Modalities, and Therapeutic Procedures:

I have been advised that chiropractic care, like all form of health care, holds certain risks. While the risk are most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.

Treatment objectives as well as the risks associated with chiropractic adjustments and, all other procedures provided at Relentless Chiropractic have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

_____ ___/___/___ _____

Patient or Authorized Person's Signature Date Witness Initials

## REGARDING: X-rays/Imaging Studies

FEMALES ONLY → please read carefully and check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our receptionist for further explanation.

☐ The first day of my last menstrual cycle was on ___-___-___ (Date)

☐ I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant.

By my signature below I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

_____ ___/___/___ _____

Patient or Authorized Person's Signature Date Witness Initials

**RELENTLESS CHIROPRACTIC NOTICE OF PRIVACY PRACTICE**

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your **P**ersonal **H**ealth **I**nformation. In addition, we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as **dictated by our office policy,** we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstance. If you would like a more detailed explanation, one will be provided to you. In addition, you will find we have placed several copies in report folders labeled **'HIPAA'** on tables in the reception area.

**PERMITTED DISCLOSURES:**

1. **Treatment purposes** – discussion with other health care providers involved in your care.
2. **Inadvertent disclosures** – open treating area mean open discussion. If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room.
3. **For payment purposes** – to obtain payment from your insurance company or any other collateral source.
4. **For workers compensation purposes** – to obtain payment from your insurance company or any other collateral source.
5. **Emergency** – in the event of a medical emergency we may notify a family member.
6. **For Public health and safety** – in order to prevent or lessen a serious or eminent threat to the health or safety of a person or general public.
7. **To Government agencies or Law enforcement** – to identify or locate a suspect, fugitive, material witness or missing person.
8. For military, national security, prisoner and government benefits purposes.
9. **Deceased persons** – discussion with coroners and medical examiners in the event of a patient's death.
10. **Telephone calls or emails and appointment reminders** – **we may call your home and leave messages** regarding a missed appointment or apprize you of changes in practice hours or upcoming events.
11. **Change of ownership** – in the event this practice is sold, the new owners would have access to your **PHI**.

**YOUR RIGHTS:**

1. To receive an accounting of disclosures.
2. To receive a paper copy of the comprehensive "Detail" Privacy Notice.
3. To request mailings to an address different than residence.
4. To request Restrictions on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction.
5. To inspect your records and receive one copy of your records at no charge, with notice in advance.
6. To request amendments to information. However, like restrictions, we are not required to agree to them.
7. To obtain **one copy** of your records at no charge, when timely notice is provided (72 hours). **X-rays** are original records and you are therefore not entitled to them. If you would like us to outsource them to an imaging center, to have copies made, we will be happy to accommodate you. However, you will be responsible for this cost.

**COMPLAINTS:**

If you wish to make a formal complaint about how we handle your health information, then please call Sean Ostrowski, D.C. at (706) 642-4476. If he is unavailable, you may make an appointment with our receptionist to see him within 72 hours or 3 working days. If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Ave. SW
Room 509F HHH Building
Washington DC 20201

Patient Name: _____ Date of Birth: _____

## RELENTLESS CHIROPRACTIC NOTICE REGARDING YOUR RIGHT TO PRIVACY

I have received a copy of Relentless Chiropractic's Patient Privacy Notice. I understand my rights as well as the practice's duty to protect my health information, and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this "Notice of Privacy Practice" at a time in the future and will make the new provisions effective for all information that it maintains past and present.

I am aware that a more comprehensive version of this "Notice" is available to me and several copies kept in the reception area. At this time, I do not have any questions regarding my rights or any of the information I have received.

_____ _____
Patient's Signature Date

## MEDICAL RELEASE

**Release of Information:**

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse: _____

[ ] Child(ren):_____

[ ] Other:_____

[ ] Information is not to be released to anyone.

This **Release of Information** will remain in effect until terminated by me in writing.

**Messages:**

Please call: [ ] My Home:_____ [ ] My Work:_____ [ ] My Mobile Number: _____

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ] _____

The best time to reach me is (day) _____ between (time) _____

_____ _____ _____
Patient's Signature Date HR#

_____ _____
Witness Signature Date