Marsing Chiropractic
PO Box 252 / 7A Reich
Marsing, Idaho 83639
(208)896-5520

Name_____ Home Phone_____/Cell_____
Age_____ Birth Date - month:____day: ____year:_____ Marital Status: M S D W / # of Children_____
Address_____City/St_____Zip_____
Occupation_____Employer_____
Address of employ_____Office Phone_____
Name of Spouse _____Occupation_____
Employer_____Office phone_____
Patients nearest relative_____Address_____
Referred By_____Date of last physical exam_____

Where did you hear about us?_____

Have you ever suffered from?

1. Dizziness	□ YES □ NO	8. Asthma	□ YES □ NO
2. Backaches	□ YES □ NO	9. Neuritis	□ YES □ NO
3. Heart trouble	□ YES □ NO	10. Digestive disorders	□ YES □ NO
4. Diabetes	□ YES □ NO	11. Nervousness	□ YES □ NO
5. Tuberculosis	□ YES □ NO	12. Sinus trouble	□ YES □ NO
6. Arthritis	□ YES □ NO	13. Anemia	□ YES □ NO
7. Headaches	□ YES □ NO	14. Cancer	□ YES □ NO

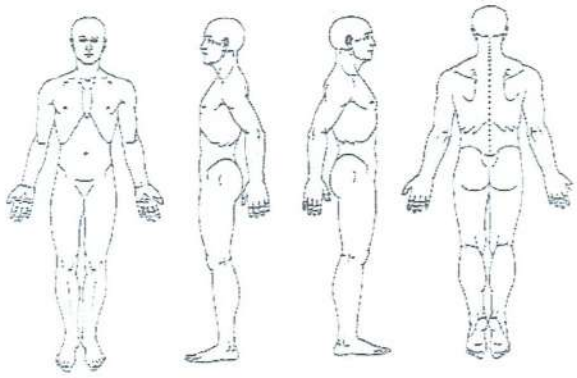
Purpose of appointment: _____
Other doctors seen for this condition _____

Have you been treated for any other health condition in the last year? □ YES □ NO

Please describe:

_____
_____
_____
_____
_____

Please mark on the drawings where the pain is using key



Pins and needles ➔ 0000 Stabbing pain ➔ ////
Burning pain ➔ XXX Deep ache ➔ ZZZ

Date problem started or flare-up of pain began:
_____

Is your current problem related to?
- [ ] Chronic Condition
- [ ] Old Injury / Injuries
- [ ] Recent Auto Accident
- [ ] Recent Work Injury

How did the problem begin or start?
- [ ] Accident / Trauma
- [ ] Gradual onset
- [ ] Sudden onset
- [ ] After Home activities

Please Circle the level of pain you have right now:

No Pain 0 1 2 3 4 5 6 7 8 9 10 **Unbearable Pain**

How often are your symptoms present?
- [ ] 0 - 25%
- [ ] 26- 50%
- [ ] 51- 75%
- [ ] 76-100%

What activities are painful?
- [ ] Movement of painful or injured area
- [ ] Bending and Stooping
- [ ] Sitting
- [ ] Walking
- [ ] Standing
- [ ] Lifting
- [ ] Pushing & Pulling
- [ ] Overhead work
- [ ] Desk Work

What make your symptoms feel better?
- [ ] Nothing
- [ ] Over the counter medication
- [ ] Prescription medication
- [ ] Rest
- [ ] Stretching
- [ ] Activity / Exercise
- [ ] Therapy

What home therapy have you tried?
- [ ] Nothing
- [ ] Heat
- [ ] Cold
- [ ] Rest
- [ ] Stretching
- [ ] Activity / Exercise
- [ ] Ointments / Rubs
- [ ] Heat Patches

Have you missed any work due to injury/pain?
- [ ] No
- [ ] Yes How many days___

Date last worked _____

What describes the nature of your complaint(s)?
- [ ] Sharp
- [ ] Dull Ache
- [ ] Shooting
- [ ] Tingling Where: _____
- [ ] Numbness Where: _____
- [ ] Burning Where: _____
- [ ] Weakness Where: _____

How are your symptoms changing?
- [ ] Getting Better
- [ ] Not Changing
- [ ] Getting Worse

When are your symptoms worse?
- [ ] Morning
- [ ] Afternoon
- [ ] Evening
- [ ] After activities
- [ ] After rest & inactivity
- [ ] Other

How is your sleep?
- [ ] Normal
- [ ] Mild Fragmented
- [ ] Very Fragmented
- [ ] Poor - little sleep

Can you perform your daily activities?
- [ ] Yes
- [ ] No

How is you appetite?
- [ ] Normal
- [ ] Changed How _____

Please answer the following questions to help determine possible risk factors:

QUESTION	YES	NO	DOCTOR'S COMMENTS
Have you ever had an adverse (i.e. bad) reaction to or following chiropractic care?	❑	❑	
Have you been diagnosed with osteoporosis?	❑	❑	
Do you take corticosteroids (e.g. prednisone)?	❑	❑	
Have you been diagnosed with compression fracture(s) of the spine?	❑	❑	
Have you ever been diagnosed with cancer?	❑	❑	
Do you have any metal implants or biomechanical devices such as a pacemaker or insulin pump?	❑	❑	
Do you take aspirin or other pain medication on a regular basis?	❑	❑	
If yes, about how much do you take daily? _____			
Do you take warfarin (coumadin), heparin, or other similar "blood thinners"?	❑	❑	
Have you ever been diagnosed with any of the following disorders/diseases?			
• Rheumatoid arthritis	❑	❑	
• Reiter's syndrome, ankylosing spondylitis, or psoriatic arthritis	❑	❑	
• Giant cell arteritis (temporal arteritis)	❑	❑	
• Osteogenesis imperfecta	❑	❑	
• Ligamentous hypermobility such as with Marfan's disease, Ehlers-Danlos syndrome	❑	❑	
• Medial cystic necrosis (cystic mucoid degeneration)	❑	❑	
• Bechet's disease	❑	❑	
• Fibromuscular dysplasia	❑	❑	
Have you ever become dizzy or lost consciousness when turning your head?	❑	❑	
Have you had spinal surgery? (If yes, when? _____)	❑	❑	
Have you been diagnosed with spinal stenosis?	❑	❑	
Have you had any of the following problems?			
• Sudden weakness in the arms or legs?	❑	❑	
• Numbness in the genital area?	❑	❑	
• Recent inability to urinate or lack of control when urinating?	❑	❑	

I have read the previous information regarding risks of chiropractic care and my doctor has explained my risks (if any) to me and suggested alternatives when those risks exist. I understand the purpose of my care and have been given an explanation of the treatment, the frequency of care, and alternatives to this care. All of my questions have been answered to my satisfaction. I agree to this plan of care understanding any perceived risk(s) and alternatives to this care.

PATIENT'S SIGNATURE _____ DATE _____

PARENT/GUARDIAN SIGNATURE _____ DATE _____
(if appropriate)

DOCTOR'S SIGNATURE _____ DATE _____

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Marsing, ID 83639
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INFORMED CONSENT

Chiropractic Health Care is an art and a science that is primarily concerned with the relationship between structure and function of the spine. The doctor of chiropractic evaluates the patient using standard examination and testing procedures (such as orthopedic and neurologic evaluation, x-rays) along with specialized chiropractic evaluation. The primary goal of chiropractic treatment is the correction of spinal dysfunction or misalignment. This is accomplished by performing a procedure unique to the chiropractic profession called an "adjustment" or manipulation. A chiropractic adjustment involves the application of a quick, precise force directed over a very short distance to the restricted segment. There are a number of different techniques that may be used to deliver the adjustment, some of which utilize specially designed equipment. Adjustments are usually performed by hand but may also be performed by hand-guided instruments. In addition to adjustments, other treatments used by chiropractors include physiotherapy modalities (heat, ice, ultrasound, soft-tissue manipulation), nutritional recommendations and rehabilitative procedures.

As is the case with all health care interventions, the benefits of care must be weighed against the inherent risks and limitations of receiving treatment. Chiropractic treatments are one of the safest interventions available to the public. While there are risks involved with treatment, these are seldom great enough to contraindicate care. Nonetheless, they must be considered when making the decision on whether or not to receive chiropractic care. Listed below are summaries of some key research articles that have addressed both common and rare side-effects/complications associated with chiropractic care.

Most Commonly Reported Reactions During First Two Months of Chiropractic Care [1]:

- Local discomfort (53%)
- Headache (12%)
- Tiredness (11%)
- Radiating discomfort (10%)

Most symptoms appeared within 4 hours of treatment and resolved within 24 hours.

Rare, Yet Possible Side-Effect/Complications

- Rib fracture
- Burns (if certain types of physiotherapy are used in your treatment)
- Disc herniation
- Cauda equina syndrome [2] (1 case per 100 million adjustments)
- Compromise of the vertebrobasilar artery (i.e. stroke) (1 case per 1 million to 2.5 million cervical spine adjustments) [3]

Through questioning and examination, your doctor of chiropractic will do his/her best to determine what risk, if any, chiropractic care may pose to you and advise you of those risks as well as the possible need for medical referral. He/she will also suggest alternate chiropractic or medical techniques if absolute or relative contraindications to the standard chiropractic treatment are detected.

1. Senstad O, et al. . Frequency and characteristics of side effects of spinal manipulative therapy. Spine 1997;22:435-41
2. Shekelle PG, et al. Spinal manipulation for low-back pain. Ann Intern Med 1992;117(7):590-8.
3. Haldeman S, et al. Risk factors and precipitating neck movements causing vertebrobasilar artery dissection after cervical trauma and spinal manipulation. Spine 1999;(24):785-94.
4. Haldeman S, et al. Guidelines for chiropractic quality assurance and practice parameters. Aspen Publishers, 1997.

I have read and understand the risks, however rare to receiving chiropractic manipulation

Sign_____ **Date**_____

FEES ARE PAYABLE WHEN SERVICES ARE RENDERED UNLESS SPECIAL ARRANGEMENTS HAVE BEEN MADE.

Have you had chiropractic care before? _____
When_____
Do you have health insurance? _____
What company? _____
If using Medicare or health insurance we will need your Social Security Number /Medicare ID number _____

I give permission to Dr. Mark W. Gibson and /or his staff to take necessary x-rays, perform necessary tests and to render chiropractic care. I understand that x-rays and files are all part of this office and as an element necessary for continuing care, are the property of the office.

I _____, request that payment of authorized Medicare/ other insurance benefits be made on my behalf to Mark W. Gibson D.C. for any services rendered to me. I authorize any holder of medical or other information about me to the Social Security Administration and Health Care Financing Administration or it's carriers any information needed for processing my medical claims. I permit a copy of this authorization to be used in place of the original, and request payment to be made to the physician who accepts assignment. I understand it is mandatory to provide the physician with information of any other parties responsible for my health care treatment.

Nearly all insurance policies provide chiropractic coverage, but benefits vary from company to company and policy to policy. Therefore, although we will fill out the insurance forms, the patient is personally responsible for payment of services rendered. We do accept certain insurance arrangements but all insurance arrangements must be approved in advance.

Signature_____

Legal Name PRINTED_____

Date_____

Our office is concerned with two things, your health and our reputation. Therefore, we accept only those patients whom we sincerely believe we can help.

Marsing Chiropractic 7A Reich St. / P.O. Box 252 Marsing, ID (208)896-5520

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, have received a copy of this office's Notice of Privacy Practices. I understand that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the healthcare providers who may be directly and indirectly involved in providing my treatment.
- Obtain payment from third-party payors.
- Conduct normal healthcare operations such as quality assessments and accreditation.

_____

{Please Print Name}

_____

{Signature}

_____

{Date}

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)_____

_____

Staff Signature Date