Today's Date: _____

KELLEY chiropractic
1503 Larson Street
Bloomer, WI 54724
715-568-4220

ABOUT YOU

Name: _____

What you prefer to be called: _____

Birthdate: _____ Age: _____ ◯ Female ◯ Male

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

I would like to receive text message alerts of upcoming appts. ____ Cellular Carrier: _____

Email Address: _____

Referred By: _____

Employer: _____

Address: _____

City: _____ State: _____ Zip: _____

Work Phone: _____ Occupation: _____

Marital Status: ◯ Single ◯ Married ◯ Divorced ◯ Separated ◯ Widowed

Spouse's Name: _____

REASON FOR YOUR VISIT

Have you ever been treated by a Chiropractor before? ◯ Yes ◯ No

If yes, please explain: _____

The reason for this visit is a result of: (Please circle) Work Sports Auto Trauma Chronic

Explain what happened: _____

Describe the pain and location: _____

When did the condition begin: _____

Is this condition getting worse (Please circle) : Yes No Constant Comes and goes

Is this condition interfering with your (Please circle): Work Sleep Daily Routine

If yes, please explain: _____

Have you had this or similar conditions in the past? ◯ Yes ◯ No

If yes, please explain: _____

Have you been treated by a Medical Physician for this condition? ◯ Yes ◯ No

If yes, where? _____

HEALTH HISTORY

Are you taking any of the following medications?

◯ **Nerve Pills** ◯ **Muscle Relaxers** ◯ **Stimulants** ◯ **Pain Killers (including aspirin)**

◯ **Tranquilizers** ◯ **Blood Thinners** ◯ **Insulin** ◯ **Other(s)** _____

Have you ever had any of the following diseases/medical condition(s)? (Please circle Y or N)

Y N Heart Attack/Stroke	**Y N Heart Surgery/Pacemaker**	**Y N Heart Murmur**
Y N Congenital Heart Defect	**Y N Mitral Valve Prolapse**	**Y N Artificial Valves**
Y N Alcohol/Drug Abuse	**Y N Venereal Disease**	**Y N Hepatitis**
Y N HIV+/Aids	**Y N Shingles**	**Y N Cancer**
Y N Frequent Neck Pain	**Y N Emphysema/Glaucoma**	**Y N Anemia**
Y N High/Low Blood Pressure	**Y N Psychiatric Problems**	**Y N Rheumatic Fever**
Y N Severe/Frequent Headaches	**Y N Kidney Problems**	**Y N Ulcers/Colitis**
Y N Fainting/Seizures/Epilepsy	**Y N Sinus Problems**	**Y N Asthma**
Y N Diabetes/Tuberculosis	**Y N Difficulty Breathing**	**Y N Chemotherapy**
Y N Lower Back Problems	**Y N Artificial Bones/Joints**	**Y N Arthritis**

Please list any other serious medical condition(s) you have or ever had: _____

_____

Please list anything that you may be allergic to: _____

List previous surgeries/treatments with dates: _____

_____

List any PAST serious accidents with dates: _____

_____

Do you smoke? ◯ **No** ◯ **Yes / How much?** _____ **How long?** _____

FOR WOMEN ONLY: Are you taking birth control? ◯ **Yes** ◯ **No**

Are you pregnant? ◯ **No** ◯ **Yes / How long?** _____ **Nursing?** ◯ **Yes** ◯ **No**

We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.

Please initial below:

_____ Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the office manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for any expenses incurred in collecting your account.

_____ I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process my insurance claims.

_____ I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my medical status.

_____ _____

Signature **Date**

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ACKNOWLEDGEMENT

I acknowledge that I have received a copy of the Practice's Privacy Notice that has an effective date of September 23, 2013.

Name of Patient (Printed)	**Signature of Patient (or guardian if under 18)**

Date: _____

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Today's Date: _____

Name: _____

Date of Birth: _____

ELECTRONIC HEALTH RECORDS (HER) FORM FOR NEW AND RETURNING PATIENTS

In order to best serve your medical needs, we ask that you complete the following questionnaire as completely as possible. As we move toward EHR's in our office, it is important that we have correct and thorough records on file for every patient. By completing and signing this form, you acknowledge that you have, to the best of your ability, provided accurate information and agree to its use electronically as defined under Permitted Uses and Disclosures according to HIPPA guidelines.

ACTIVE MEDICATIONS

List all medications you are currently taking, including any over the counter drugs.

Medication Name	***Dose***	***Frequency***

_____

Signature of Patient or Guardian if under 18

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INFORMED CONSENT

Chiropractic, as well as other types of health care, is associated with potential risks in delivery of treatment. Therefore it is necessary to inform the patient of such risks prior to initiating care. While chiropractic treatment is remarkably sake, you need to be informed about the potential risks related to your care to allow you to be fully informed in consenting to treatment.

Chiropractic offices use trained stall personnel to assist with portions of your consultation, examination, x-rays, physical therapy applications, exercise instruction, etc. Occasionally when your chiropractor is unavailable, another qualified Doctor of Chiropractic may treat you.

SPECIFIC RISK POSSIBILITIES ASSOCIATED WITH CHIROPRACTIC CARE:
STROKE: Stroke is the most serious complication of chiropractic treatment. It is on rare occasions, due to injury of the vertebral artery caused by a cervical spine adjustment or manipulation, and when occurs, may cause temporary or permanent brain dysfunction. On extremely rare occasions death occurs. Because the vertebral arteries, which supply the brain with blood, are located within the bones of the cervical spine, cervical treatment poses small risk. The chances of this occurring are estimated at 1 per 400,000 treatments to 1 per 10,000,000 treatments. The most recent studies (journal of the CCA, Vol. 37, No. 2, June, 1993) estimate that the incidence of this type of stroke is 1 in every 3,000,000 upper cervical adjustments.

SORENESS: Chiropractic adjustments and the physical therapy procedures are sometimes accompanied by posttreatment soreness. This is normal and acceptable accompanying response to chiropractic care. While it is not generally dangerous, please advise your Doctor of Chiropractic if you experience soreness or discomfort.

SOFT TISSUE INJURY: Occasionally chiropractic treatment may aggravate a disc injury, or cause other minor joint, ligament, tendon, or other soft tissue injury.

RIB INJURY: Manual adjustments to the thoracic spine, in rare cases, may cause rib injury or fracture. Precautions such as pre-adjustment x-rays are taken for cases considered at risk. Treatment is performed carefully to minimize such risk.

PHYSICAL THERAPY BURNS: Heat generated by physical therapy modalities may cause minor burns to skin. These are rare, but should be reported to your Doctor of Chiropractic of staff if they occur.

OTHER PROBLEMS: There are occasionally other type of side effects associated with chiropractic care. These are rare, they should be reported to your Doctor of Chiropractic promptly.

Chiropractic is a system of health care delivery and therefore, as with any health care delivery system, we cannot promise a cure for any symptom, condition, or disease as a result of treatment in this office. An attempt to provide the very best care is our goal and if the results are not acceptable, we will refer you to another provider who we feel will assist your situation.

If you have any questions concerning the above, please ask your Doctor of Chiropractic. When you have full understanding and consent to have care provided, please print your name, sign, and date below.

HAVING CAREFULLY READ THE ABOVE, I HEREBY GIVE MY INFORMED CONSENT TO HAVE CHIROPRACTIC TREATMENT ADMINISTERED.

_____ _____
Patient Name Printed Parent of Guardian for Minor

_____ _____
Patient Signature Date

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CONSENT TO TREAT A MINOR CHILD

I hereby authorize Kelley Chiropractic to administer treatment as deemed necessary, to my

- ◯ Son
- ◯ Daughter
- ◯ Dependent

_____
Patient Name Printed

_____ _____
Parent or Guardian Name Printed Date

_____ _____
Parent or Guardian Signature Witness