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

I understand that Kelley Chiropractic performs manual therapy techniques, physical therapy procedures, exercise, and dry needling as part of its treatment protocol. Although chiropractic care is considered to be one of the safest, most effective forms of therapy for musculoskeletal problems, I am aware that any form of treatment has potential risks and complications associated with it.

Risks of Chiropractic Treatment:

Soreness: Like exercise, it is common to experience muscle soreness in the first few treatments.
Dizziness: Temporary symptoms like dizziness and nausea may occur, but are relatively rare.
Rib/Joint Injury: This may include rib fracture or rib cartilage sprain. Conditions like physical defects, osteoporosis, or arthritis may increase this risk. Treatment precautions are taken to minimize the risk.
Stroke: While strokes can happen from a multitude of factors, strokes from chiropractic adjustments are rare and no greater than the general medical population. Studies estimate the risk at 1:1 million to 1:5 million. Risk is decreased by minimizing neck rotation. That is the protocol we utilize in our clinic.
Burns: Some electric therapies generate heat and may cause a burn, resulting in a temporary increase of pain and possible blistering. Our machines are calibrated regularly, and individual patient pads are used.

Risks of Dry Needling:

Drowsiness: May occur after treatment (infrequently). If affected, you are advised not to drive.
Minor Bleeding/Bruising: May occur after acupuncture (~ 3% of patients) or during cosmetic procedures.
Pain: During treatment may occur (~ 1% of patients).
Increase in Symptoms: Worsening after treatment (< 3% of patients). You should tell your doctor about this, but it is usually a good sign that acupuncture will be beneficial.
Fainting: Can occur in certain patients, particularly at the first treatment.
Pneumothorax: This may occur when treating points over the lung.
Infection (rare): We use pre-sterilized, one-time-use, disposable needles to reduce this risk.

Alternative Treatment Options & Risks:

Reasonable alternatives and risks to these procedures are available to me, including:
Medications: These can reduce pain or inflammation. Long-term use/overuse of drugs may mask pathology, produce inadequate or short-term relief, undesirable side-effects, physical or psychological dependence, and may have to be continued indefinitely. Some medications may involve serious risks.
Surgery: Surgery may be necessary for joint stability or serious disk rupture. Surgical Risks may include unsuccessful outcome, pain, reaction to anesthesia, prolonged recovery, serious complications or death.
Rest/Exercise: Simple rest is not likely to reverse pathology, although it may temporarily reduce inflammation and pain. The same is true of ice, heat, or other home therapy. Prolonged bed-rest contributes to weakened bones and joint stiffness. Exercises alone are of limited value but do not correct injured nerve and joint tissues.
Non-Treatment: Neglecting care can increase pain, accelerate degeneration, cause nerve damage, increase inflammation, and worsen pathology. This may complicate treatment, making it more difficult and less effective the longer it is postponed.

Treatment Results:

I realize that the practice of medicine, including chiropractic, is not an exact science. I acknowledge that no guarantee has been made to me regarding the outcome of these procedures. I agree with the performance of these procedures by my doctor and such other persons of the doctor's choosing.

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 form to apply to all my present and future treatments at this clinic.

_____ _____
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