Back2Health Chiropractic Clinic

James R. Robertson, DC

2918 Saint Mary's Avenue
Hannibal, MO 63401
Phone: (573) 221-5553

Patient Information Form

Patient Contact Information

Today's Date: ____ / ____ / 20____
Name: _____
Age: _____ Gender: [ ] M [ ] F
SSN: _____
Email: _____
Address: _____
City/State/Zip: _____
Date of Birth: _____

Home Phone: _____
Cell Phone: _____
Occupation: _____
Employer: _____
Work Phone: _____
Work Address: _____

Demagraphic Information

Marital Status

[ ] Single
[ ] Married
[ ] Separated
[ ] Divorced
[ ] Widowed
[ ] Partnered for _____ years
[ ] Decline to provide

Primary Language

[ ] English
[ ] Other (list): _____

Ethnicity

[ ] Non-Hispanic
[ ] Hispanic
[ ] Other: _____

Race

[ ] White
[ ] American Indian
[ ] Asian
[ ] Black/African American
[ ] Native Hawaiian
[ ] Decline to provide

Smoking Status

[ ] Current Everyday Smoker
[ ] Current Some Day Smoker
[ ] Former Smoker
[ ] Never Smoker
[ ] Unknown

Insurance Information

[ ] Self-Pay or [ ] Insured's Name: _____

Is this due to an accident? [ ] Yes [ ] No
[ ] Work Comp Injury (Date of Injury): _____ Reported to: _____
[ ] Auto Accident Claim #: _____
- Adjuster's Name: _____ Phone: _____
[ ] Home Accident [ ] School Accident [ ] Other (explain): _____

Attorney's Name: _____ Phone: _____
Address: _____

Medical Information

Allergies

[ ] Animals
[ ] Penicillin
[ ] Aspirin
[ ] Ragweed/Pollen
[ ] Bees
[ ] Rubber
[ ] Chocolate
[ ] Seasonal Allergies
[ ] Dairy
[ ] Shellfish
[ ] Dust
[ ] Soaps
[ ] Eggs
[ ] Wheat
[ ] Latex
[ ] X-Ray Dye
[ ] Molds
[ ] Other: _____
_____
_____

Surgeries

[ ] Back
[ ] Shoulder
[ ] Brain
[ ] Wrist
[ ] Elbow
[ ] Foot
[ ] Hip
[ ] Knee
[ ] Neck
[ ] Other: _____
_____
_____

Past Medical History

[ ] Ankle Pain
[ ] Arm Pain
[ ] Arthritis
[ ] Asthma
[ ] Back Pain
[ ] Broken Bones
[ ] Cancer
[ ] Chest Pain
[ ] Depression
[ ] Diabetes
[ ] Dizziness
[ ] Eye/Vision Issues
[ ] Fatigue
[ ] Genetic Spinal Condition
[ ] Headaches
[ ] High Blood Pressure
[ ] HIV
[ ] Jaw Pain
[ ] Joint Stiffness
[ ] Knee Pain
[ ] Leg Pain
[ ] Menstrual Issues
[ ] Mid-Back Pain
[ ] Minor Heart Issues
[ ] Neck Pain
[ ] Neurological Issues
[ ] Pacemaker
[ ] Parkinson's Disease
[ ] Prostate Issues
[ ] Shoulder Pain
[ ] Stroke/Heart Attack
[ ] Other: _____
_____
_____

Family Medical History

List any family members with conditions (e.g., "High Blood Pressure – Grandmother"):

_____
_____
_____

Signature: _____ Date: _____

Whom may we thank for referring you? _____

JAMES ROBERTSON, D.C. 2918 ST. MARY'S AVE, HANNIBAL MO

BACK 2 HEALTH CHIROPRACTIC CLINIC

CONSENT TO SHARE PROTECTED HEALTH INFORMATION

(1) **I hereby authorize** Back 2 Health Chiropractic Clinic, James R Robertson, DC to provide my PHI (Protected Health Information) to the following person(s) I have listed below. This could be a family member such as a parent, spouse/significant other, or a family friend. Please list the names and relationship below.

I understand that I may cancel this consent at any time (in writing), but that canceling it will not affect any information that has already been released. This authorization expires:

☐ When I cancel it in writing or If no expiration date or event is specified, this authorization will expire one (1) year after the date of signature.

NAME of trusted persons mentioned above RELATIONSHIP to such person

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

SIGNATURE OF THE PATIENT OR LEGAL REPRESENTATIVE DATE

_____ _____

PRINTED NAME OF THE PATIENT WITNESS

Don't sign (2) if you signed (1) above.

(2) **I DON'T** AUTHORIZE ACCESS OF MY PHI (PROTECTED HEALTH INFORMATION) TO ANYONE

I understand that I may cancel this consent at any time (in writing), but that canceling it will not affect any information that has already been released. This authorization expires:

☐ When I cancel it in writing or If no expiration date or event is specified, this authorization will expire one (1) year after the date of signature.

_____ _____

SIGNATURE OF THE PATIENT OR LEGAL REPRESENTATIVE DATE

_____ _____

PRINTED NAME OF THE PATIENT WITNESS

JAMES ROBERTSON, D.C. 2918 ST. MARY'S AVE, HANNIBAL MO

Back 2 Health Chiropractic Clinic

Consent to Treatment of Minor

We, the undersigned parent(s) and/or guardian(s) of _____ (child's name), do hereby authorize Back 2 Health Chiropractic Clinic and its doctors to administer chiropractic care to my child, as they deem necessary.

It is understood that this authorization is given in advance of any specific diagnosis or treatment being required to provide authority to the above-described agents to give specific consent to any and all such diagnosis and treatment which the chiropractor, meeting the requirements of this authorization, may, in the exercise of his/her best judgment, deem advisable.

This authorization will expire one (1) year after the date of signature unless sooner revoked in writing delivered to James R. Robertson, DC or Back 2 Health Chiropractic Clinic. If I do not sign this notice or revoke the consent at any time, the Practice has the right to refuse to treat the minor.

_____ _____

SIGNATURE OF THE PATIENT OR LEGAL REPRESENTATIVE DATE

_____ _____

PRINTED NAME OF THE PATIENT WITNESS

JAMES ROBERTSON, D.C. 2918 ST. MARY'S AVE, HANNIBAL MO

Back 2 Health Chiropractic Clinic

HIPAA • Notice of Our Privacy Practices

Consent for purposes of treatment, payment, and healthcare operations as required by the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

This notice is valid for seven (7) years. You have the right to revoke this notice in writing at any time, except to the extent that the practice has taken action in reliance on this consent. If you do not sign this notice or revoke this consent at any time, the practice has the right to refuse to treat you.

PHI includes health information, demographic information, and any information collected or received by a physician, healthcare provider, employer, or health plan that relates to past, present, or future physical or mental health conditions and identifies the individual.

I consent to the use or disclosure of my protected health information by the practice for the purpose of analyzing, diagnosing, or providing treatment to me, obtaining payment for my healthcare bills, or conducting healthcare operations of the practice. I understand that my treatment may be conditioned upon my consent as evidenced by my signature below.

I understand that I have the right to request restrictions on how my protected health information is used or disclosed for treatment, payment, or healthcare operations. The practice is not required to agree to these restrictions, but if the practice agrees, the restriction is binding.

The practice reserves the right to change the privacy practices described in the notice. I may obtain a revised notice of privacy practices by calling the office and requesting a copy be sent by mail or asking for one at the time of my next appointment.

I have been provided with a copy of the notice of privacy practices of the practice and understand that I have the right to review the notice prior to signing this document. The notice describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or in the performance of healthcare operations of the practice. The notice of privacy practices for the practice is also posted in the waiting room at the practice's locations. The notice also describes my rights and duties of the chiropractor with respect to my protected health information.

_____ _____

SIGNATURE OF THE PATIENT OR LEGAL REPRESENTATIVE DATE

_____ _____

PRINTED NAME OF THE PATIENT WITNESS

JAMES ROBERTSON, D.C. 2918 ST. MARY'S AVE, HANNIBAL MO

Back 2 Health Chiropractic Clinic

Informed Consent to Care

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

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. 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.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, dislocations, strains, and sprains. In addition, the literature recognizes an association between strokes and chiropractic manipulation of the cervical spine. With respect to strokes, there is a rare but serious condition known as an "arterial dissection" that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Carotid and vertebral artery dissections are rare, with an annual incidence of 2.5 - 4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately, a percentage of these patients will experience a stroke.

The reported association between visits to a chiropractor or a primary care physician and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million visits.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

_____ _____

SIGNATURE OF THE PATIENT OR LEGAL REPRESENTATIVE DATE

_____ _____

PRINTED NAME OF THE PATIENT WITNESS