Park Chiropractic, P.C. Confidential Patient Case History

Please complete this form and if you have questions, do not hesitate to ask for assistance. We will be happy to help. **(Please type/print neatly.)**

General Information

For Office Use Only Account # _____

First Name:_____ **Initial:**_____
Last Name:_____

Phone #:_____ **Phone #:**_____

Address:_____

City:_____ **State:**_____ **Zip:**_____

SS#:_____ **Birth Date:**____/_____/_____

Gender Assigned at Birth:
☐ Male ☐ Female

Chosen Gender
☐ Male ☐ Female ☐ _____

Email Address:_____

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

Smoking Status (mark only 1) ☐ Current Everyday Smoker ☐ Former Smoker
☐ Current Some Day Smoker ☐ Never Smoker

Spouse name:_____ **#Children**_____ **Referred By:**_____

Do you have Health Insurance? ☐ Yes ☐ No If yes, what kind? Ins #

This is a Confidential Health Report

Single click/or mark with "X" on check boxes to mark a selection

Please describe your major complaint that brought you into the office today:_____
_____ When did this condition begin?_____
What caused this condition?_____
Have you had this before? ☐ Yes ☐ No Is this condition getting progressively worse? ☐ Yes ☐ No

If yes, how often does it occur? ☐ Occasional ☐ Frequent ☐ Constant ☐ Absent For how long?_____
When is this condition the worst? ☐Constantly ☐A.M. ☐Midday ☐Evening ☐Bedtime

Does the pain radiate into an extremity? ☐ Yes ☐ No If yes, where?_____
What aggravates this condition? _____
What makes this condition better? _____
Are you taking any medications? ☐ Prescription ☐ OTC ☐ Vitamins ☐ Holistic ☐ None (*please print neatly and clearly)*
Please list with dose (s): _____
Do you have an allergy to any medication(s) ☐ Yes ☐ No If yes; please list below (*PRINT neatly*)
_____
Have you ever had any surgeries, falls or accidents? ☐ Yes ☐ No If yes, please describe below
_____
Are you wearing? ☐ Heel Lifts ☐ Sole Lifts ☐ Inner Soles ☐ Arch Supports
Have you been in an auto accident? ☐ Past year ☐ Past five years ☐ Over five years ☐ Never
If yes, please describe:_____
Have you had previous Chiropractic care? ☐ Yes ☐ No If yes, day of last care:_____
Do you have a primary physician? ☐ Yes ☐ No If yes, who?_____

HAVE YOU EVER			**DESCRIBE BRIEFLY**
Been knocked unconscious?	☐ Yes	☐ No	_____
Used a cane, crutch, or other support?	☐ Yes	☐ No	_____
Been treated for a spine or nerve disorder?	☐ Yes	☐ No	_____
Had a fractured bone?	☐ Yes	☐ No	Where? _____

Habits:	Heavy	Moderate	Light	Social	None
Alcohol	☐	☐	☐	☐	☐
Caffeine	☐	☐	☐	☐	☐
Exercise	☐	☐	☐	☐	☐
Sleep	☐	☐	☐	☐	☐

Date of Last:	Never	1-6 Mos.	7-18 Mos.	Over 18 Mos.	Date
Spinal Exam	☐	☐	☐	☐	_____
Physical Exam	☐	☐	☐	☐	_____
Spinal X-Ray	☐	☐	☐	☐	_____
MRI	☐	☐	☐	☐	_____

Please Check The Following: *(x symptoms you currently have or are re-occurring)*

Overall Health:

☐ Allergies
☐ Diarrhea
☐ Nausea
☐ Dizziness
☐ Poor Circulation
☐ Nose Bleeds
☐ Fainting
☐ Rapid Heartbeat
☐ Varicose Veins
☐ Constipation
☐ Sweats
☐ Asthma
☐ Persistent Cough
☐ Cold
☐ Hay Fever
☐ Difficult Digestion
☐ Difficulty Breathing
☐ Sinus Problems
☐ Headaches
☐ Fatigue
☐ Loss of Weight
☐ Wheezing
☐ Fainting
☐ Headache
☐ Loss of Sleep
☐ Numbness
☐ HIV
☐ Cancer, Type:_____
☐ Shingles
☐ Other_____
☐ Other_____
☐ Other _____
☐ Other _____

Muscle/Joint/Bone: (Pain weakness in, (x) all that apply)

☐ Arms ☐ Feet ☐ Elbows ☐ Hips ☐ Hands ☐ Legs ☐ Joints
☐ Back ☐ Knees ☐ Sciatica ☐ Tail Bone ☐ Arthritis ☐ Shoulders ☐ Posture

Women Only: Are you Pregnant? ☐ Yes ☐ No Date of start of LMP_____
☐ Irregular cycle ☐ Menopausal Symptoms ☐ Menstrual Problems ☐ Hot Flashes

Family Health Information:

Name	Relationship	Past and/or present health problems

Emergency Contact Name:_____Phone:_____

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of the staff responsible for any errors or omissions that I may have made in the completion of this form.

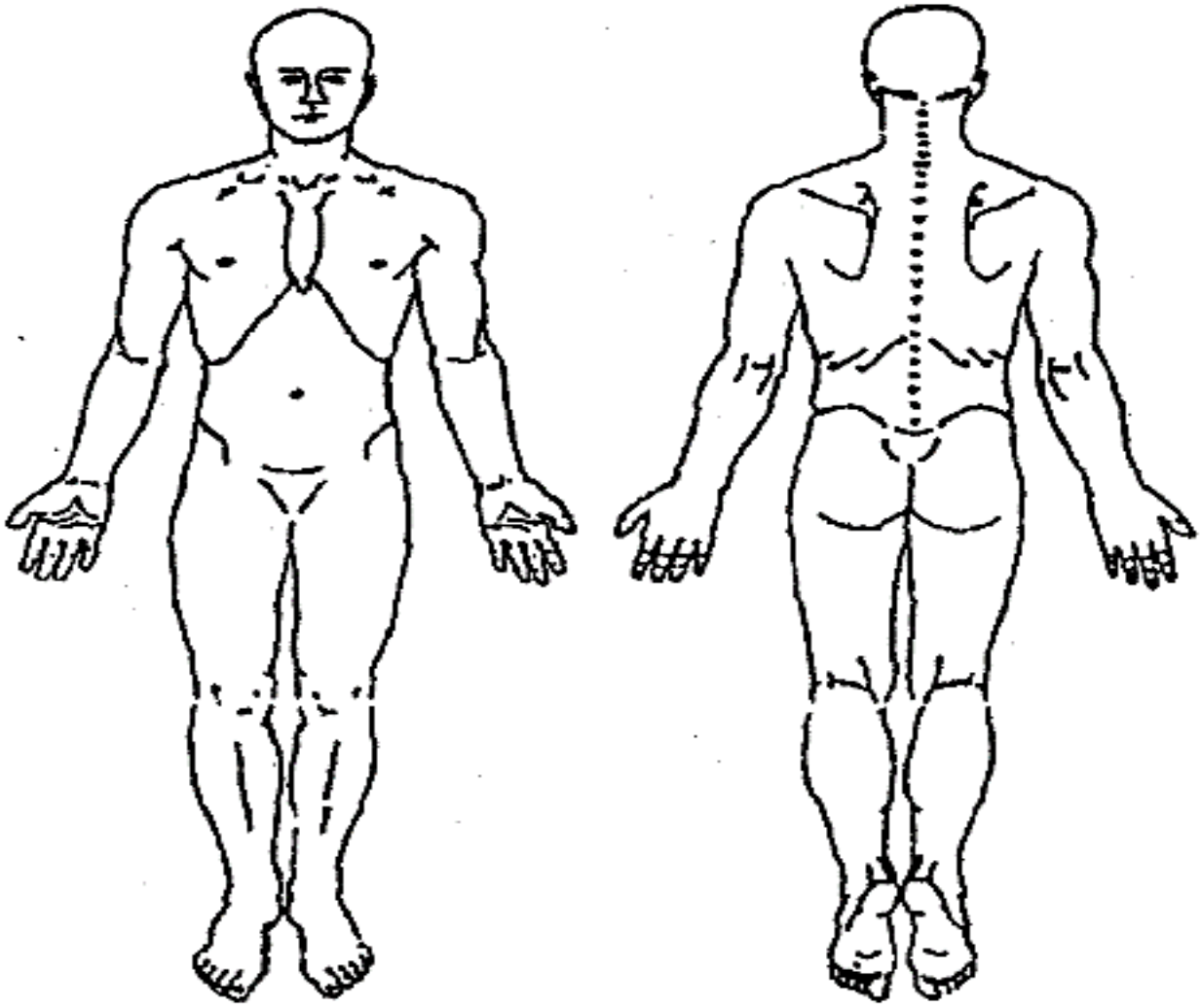
Signature: _____ **Date:** _____

NAME:_____ DATE:_____

PAIN DRAWING

Using the symbols given below, mark the area on you body where you feel the described sensations. Include all affected areas.

Aching	Numbness	Pins & Needles	Burning	Stabbing	Other
ΔΔΔΔ	=====	OOOOO	XXX	/////	.....



Are you in pain?

0 very happy, I do not hurt at all

1 - 2 hurts just a little bit

3 - 4 hurts a little more

5 - 6 hurts even more

7 - 8 hurts a whole lot

9 - 10 hurts as much as you can imagine, you don't have to be crying to feel this bad

Please mark each section of the body with the level of pain; using the pain scale to the ← ----left

Park Chiropractic, P.C.

Informed Consent to Chiropractic Care & ZERO Tolerance Policy

I hereby request and consent to the performance of chiropractic manipulation or adjustments and other chiropractic procedures, including various modes of physical therapy or physical medicine procedures, on me (or on the patient named below for whom I am legally responsible) by the doctor of chiropractic named above and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or serving as backup for the doctor of chiropractic named above.

I have had an opportunity to discuss with the Doctor of Chiropractic named above and/or with other office or clinic personnel the nature and purpose of chiropractic manipulations of adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including, but not limited to, fractures, disc injuries, strokes, dislocations, and sprains. I do not expect the doctor to be able to anticipate and explain all possible risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure, which the doctor feels at the time, based upon the facts then known, is in my best interest.

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 cover the entire course of treatment for my present conditions.

Zero-Tolerance Policy

Clients/Patients are expected to always maintain professional behavior while at Park Chiropractic. Unprofessional behavior will not be tolerated at any time, for any reason.

Unprofessional behavior is a style of interaction with physicians, clinic personnel, patients, family members, or others that interferes with patient care. Behaviors such as rude, loud, or offensive comments; sexual harassment or other inappropriate physical contact or verbal comments. Inappropriate jokes, stories, or the like; and intimidation of staff, patients, and family members are commonly recognized as detrimental to patient care **is FORBIDDEN and will NOT BE TOLERATED!**

Patient Printed Name_____

Patient/Guardian Signature_____ Date_____

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Park Chiropractic, P.C.
Massage Therapy Informed Consent

I,_____, (client) understand that massage therapy provided by, _____ , (massage therapist) is intended to enhance relaxation, reduce pain caused by muscle tension, increased range of motion, improve circulation, and offer positive experience of touch. Any other intended purposes for massage therapy are specified below:

_____

_____

The general benefits of massage, possible massage contraindications and the treatment procedure have been explained to me. I understand that massage therapy is not a substitute for medical treatment or medications, and that it is recommended that I concurrently work with my Primary Caregiver for any condition I may have. I am aware that the massage therapist does not diagnose illness or disease, does not prescribe medications, and that spinal manipulations are not part of massage therapy.

I have informed the massage therapist of all my known physical conditions, medical conditions, and medications, and I will keep the massage therapist updated on any changes. I understand that there shall be no liability on the practitioner's part due to my forgetting to relay any pertinent information.

If I experience any pain or discomfort during the session, I immediately communicate that to the therapist, so the treatment can be adjusted.

I have received a copy of the therapist's policies; I understand them and agree to abide by them.

Expectations and Rights

The client is expected to demonstrate good hygiene and not use illegal drugs or alcohol before the session (the use of drugs and alcohol make it unsafe for a client to receive massage). **Clients and therapists are expected to refrain from any behavior of a sexual nature, including sexual jokes, nicknames, or immodest conduct. Sexual behavior from the client toward the therapist is inappropriate and will lead to the termination of the session and refusal of further service.**

The therapist ***and*** the client have the right to end the session at any time should they feel dissatisfied or uncomfortable with the session in any way. Park Chiropractic is focused on **THERAPEUTIC MASSAGE ONLY! Any sexual advances, innuendo or inappropriate touch is FORBIDDEN and will NOT BE TOLERATED!**

Print Name_____Date_____

Sign_____

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PARK CHIROPRACTIC, P.C.

LATE and/or MISSED APPOINTMENT AGREEMENT

Thank you for choosing Park Chiropractic for your chiropractic care. Trying to accommodate every patient's individual needs and work schedules can be difficult, but we always try to do our best. We work extremely hard to stay on schedule so that our valuable patients will not spend time in our reception area waiting for an appointment.

Because of COVID, new health & safety processes have been implemented for our patients, staff, and community. It is imperative that we maintain allotted time in between patients to allow for proper cleaning & sanitizing.

A scheduled appointment is a commitment of time between you and our practice. We have reserved that time just for you. When appointments are late, missed or cancelled, that time is permanently lost and ultimately affects your treatment.

We ask when you schedule an appointment that you make every effort to keep that commitment and be at the clinic and checked in and ready to see your practitioner at your scheduled time. We understand that personal emergencies sometimes occur, and we always take that into consideration when receiving last minute notice or cancellation.

In order to provide the highest quality services to our patients, we have an enforced Late and/or Missed Appointment Policy. Please review the following agreement and sign at the signature line, indicating that you understand our policy.

As a patient or guardian for a patient receiving services from Park Chiropractic, I understand and agree with the following:

- I will arrive at least 5 minutes prior to my appointment time. Our text reminder system is a courtesy to me however, it is my responsibility for knowing your appointment time and to come to my appointment as scheduled. Albeit rare, there are times when the system has glitches and may cause the reminder to not be sent.
- In the event I am late, I understand I may not be able to get treatment and you may need to reschedule.
- I understand I am responsible for late fees as outlined below.
- I am responsible for canceling appointments within 24 hours prior to the appointment.
- Should I fail to attend my appointment, If I am late, or cancel my appointment within the 24-hour period prior to my appointment, Park Chiropractic will notify me of the missed appointment via letter or text.
- Appointments that are for ADJSUTMENT I will be charged $15.00 for the initial late/missed appointment and $30.00 for every following late/missed appointment.
- Appointments that are for MASSAGE I will be charged $0 for the 1st late/missed appointment, ½ of the self-pay price (~$45 - $110) for the second, and the full self-pay price (~$45 - $110) for the 3rd late/missed appointment. We will not schedule you for further massages after this point.
- All late and missed appointment fees must be paid prior to scheduling a new appointment.
- Appointments missed due to illness, adverse weather conditions or other conditions that reasonably prohibited me from canceling the appointment will not be considered late/missed appointments. I must notify Park Chiropractic of such an occurrence.
- Park Chiropractic may terminate my services due to noncompliance if I have too many missed appointments, that is three missed appointments within a twelve-month period or several missed appointments over a multiple year period. Park Chiropractic will notify me should noncompliance due to missed appointments result in termination.

Patient Printed Name_____

Patient/Guardian Signature_____ Date_____

Park Chiropractic, P.C. Insurance/Financial Notice

We are committed to providing you with the best possible care and will help you receive your maximum allowable insurance benefits. While insurance benefits, specific coverage, and co-pays can be difficult to understand as well as vary from person to person; we will try to simplify as best we can. All payment: Co-Pay, Co-Insurance, and Deductibles are collected at the time of service, unless prior arrangements have been made. We accept Cash, Check, Visa, MasterCard, AMEX, and Discover. Please note there is a $25.00 fee for all returned checks for any reason.

Insurance Agreement

- As a courtesy to you, our office will complete and file any necessary insurance forms at no additional charge. If you provide incorrect or inaccurate insurance information; your insurance company will deny your claim and will not pay for services rendered. The total charges will then be your responsibility.
- Please understand, your insurance is an agreement between you and your insurance company, not between your insurance company and our office. We are happy to offer a complimentary benefit check to verify coverage directly with your insurer; however, the **benefits quoted to us by your insurance company are not a guarantee of payment**. As a result, our office cannot be responsible for your insurer's final payment and benefit determinations.
- Some insurance policies are extremely specific to cover **ONLY Spinal Manipulation**. All other services (office exams, traction, extremity manipulation, therapies, etc.) may be subject to additional charges which will be billed directly to you.
- You are responsible for payment of any non-covered services, deductibles, or co-pays services as per your agreement with your insurance carrier, and/or any supplements you may have.
- If your insurance does not respond within 60 days, or if you suspend or terminate care, any unpaid fees for services will be due immediately.

Medicare & Medicaid

- We accept assignment from Medicare/Medicaid, our office will complete and file any necessary insurance forms at no additional charge. For **Chiropractic - ONLY manual manipulation of the spine is a covered service when deemed medically necessary**. All other services (office exams, traction, extremity manipulation, therapies, etc.) may be subject to additional charges which will be billed directly to you.
- The initial exam and any additional office exams, when it is medically necessary, is one of the services that is not covered by Medicare/Medicaid. The initial exam charge starts at $60.00.

Self-Pay & Special Arrangements

- We have never denied anyone the benefits of chiropractic care due to the inability to pay. If hardship necessitates; individual consideration and special arrangements can be made at that time.
- Each case is different, and you will normally be asked to bring a payment on your first visit. At that time and once the doctor has determined what treatment you need, we will discuss financial arrangements.

Outstanding Balances

- Accounts with balances over 30 days past due will incur a finance charge for every 30 days the account is delinquent.
- Should your account exceed 60 days past due, you will incur a $5.00 statement fee in addition to finance charges.
- Should your account exceed 120 days; a $5.00 statement fee, interest & finance charges, as well as your account will be sent to collections and immediately terminate further services.

Money Back Guarantee

- Our office is based on the simple belief that if we satisfy and delight our patients, they get well faster and will be more likely to tell others about our office. This avoids costly advertising and helps keep our fees reasonable.
- Since patient results vary, we cannot guarantee results, but we can guarantee satisfaction. If at any time within your first three office visits, you are not completely delighted with your decision to consult our office, we will happily refund the money you have paid us and make other care recommendations. You must notify us within 45 days from your first visit.
- Naturally, more visits will be necessary to complete the healing and retraining of your spine and nervous system. However, during this introductory period most patients enjoy enough progress to know that consulting our office was a wise decision.

Simple as that! Again, welcome to Park Chiropractic we are honored to assist in your health!

Signature _____ Date _____ OVER------→

Signature of Patient or Personal Representative

Park Chiropractic, P.C.

When Chiropractic Won't Help: Chiropractic Contraindications

Here is a list of the most common chiropractic contraindications for SMT:

1. **Ruptured disc.** When evaluating for a disc injury, your chiropractor will want to rule out an extruded (or ruptured) disc and will refer you out for an MRI if he or she suspects that your disc is torn. Ruptured discs CAN be successfully treated by chiropractors, but the methods of treatment will be unique to this condition.
2. **Cardiovascular problems.** When considering the potential for cardiovascular issues, your chiropractor will look for predisposing factors based upon your family history. Your chiropractor will also ask about whether you are a smoker, are on steroids or blood thinning medications, and (if you are female) whether you are on birth control medications. Your chiropractor will perform special tests to evaluate your vertebral arteries (the small arteries in your neck which run alongside and within a portion of your vertebrae).
3. **Bone weakness.** Your chiropractor will check for the structural integrity of your bones prior to SMT. If you have Osteoporosis, Rheumatoid or Osteoarthritic Degenerative Disease, special methods of SMT can be performed safely. Instruments and certain adjusting techniques can be safely used.
4. **Abnormalities.** Your chiropractor will check your spine for congenital abnormalities or space-occupying problems which could (very rarely) include tumors or disease.
5. **Infection.** Your chiropractor will check your vital signs, especially temperature, to rule outthe possibility of an infection.
6. **Problems with visceral organs.** Symptoms from the viscera and internal organs can mimic musculoskeletal symptoms and may require immediate medical or emergency room referral. (Gall bladder pain or an aortic aneurysm are examples of mimicked spinal pain.)
7. **Muscle spasms.** If you have an acute spasm of a muscle, SMT in that immediate area may or may not be appropriate.
8. **Congenital scoliosis.** Pending on age and duration of treatment, SMT may or may not decrease the progressive effects of congenital juvenile idiopathic scoliosis.
9. **Surgical hardware.** Your chiropractor will not perform SMT into surgical fusion hardware, especiallyif the surgery was recent.

The standard of care is that if your symptoms do not reduce, even a little, within the first month of the beginning treatment, then you may be referred to another type of doctor for further diagnostic testing and treatment or co-treatment.

As in all health care, remember that what can do good can also do harm. If you doubt this, pay attention to the next drug advertisement you see and hear. The litany of contraindications, side effects and adverse reactions which every medication creates is overpowering if you are not paying attention to the flowery images on your TV screen.

The chiropractor is trained to first do no harm, and to look for chiropractic contraindications. Every health care procedure has risk, but thankfully chiropractic is one of the least risky health care methods on our planet. The next time you experience musculoskeletal pain, consider chiropractic care first. A chiropractor is uniquely qualified to find the reason for your pain, rule out chiropractic contraindications, and when appropriate, successfully, and quickly help you improve!

Print Name_____ Date_____

Sign_____

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Park Chiropractic, P.C.

201 Rublein St. Ste A Marquette, MI 49855
Phone (906)226-2666; Dr. Terry Park, B.A.D.C.

Patient Health Information Consent Form

We want you to know how your Patient Health Information (**PHI**) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (**PHI**) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care.
5. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
6. For your security and right to privacy, all staff has been trained in patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
7. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
8. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.
9. I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Signature _____ Date _____

Signature of Patient or Personal Representative

Print Name _____

Printed Name of Patient or Personal Representative

_____

Description of Personal Representative

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