WELCOME TO ALPINE CHIROPRACTIC CENTER, PC

Patient Information

Patient's First Name	Initial	Last Name	Date of Birth	Gender
			/ /	❑ Male ❑ Female

Mailing Address	City	State	Zip Code

Home phone	Work phone	Cell phone
( ) -	( ) -	( ) -

Employer	Occupation	Email address

Marital Status	Pregnancy statement (for female patients)
❑ Single ❑ Married ❑ Other	❑ I **am** pregnant. ❑ I **am not** pregnant, nor is pregnancy suspected at this time. ❑ I am **not sure**.

Emergency contact name	Emergency contact phone

Medical Information

Primary care physician	Name of practice

Please describe your general symptoms:	Are your symptoms a result of:
	❑ Work injury, Date: ____/____/_____ ❑ Car accident, Date: ____/____/_____ ❑ Other injury or accident, Date: ____/____/_____

Other practitioners who have treated this condition:	How did you hear about us?

Insurance Information

Name of insured	Relationship to patient	Insured's date of birth
		/ /

Financial responsibility: I clearly understand and agree that I am personally responsible for payment in full for all services rendered to me with associated fees whether or not they are covered by insurance. I agree that I am responsible for obtaining coverage information directly from my insurance company, and I acknowledge that Alpine Chiropractic Center PC is not responsible for collecting or communicating this information to me. If as a courtesy, this information is discussed with me, Alpine Chiropractic Center PC and its associates shall not be held liable for the accuracy or completeness of the information.

INSURANCE BILLING: I understand that Alpine Chiropractic Center, PC. will bill my insurance company as a courtesy upon presentation of a current insurance card, and I authorize the release of any information necessary to assist me in making collection from the insurance company. I permit Alpine Chiropractic Center, PC. to credit my account with amounts paid upon receipt and to endorse co-issued remittances for the conveyance of credit to my account. I UNDERSTAND THAT ALL BILLS ARE ULTIMATELY MY RESPONSIBILITY.

LIENS: I understand that Alpine Chiropractic Center may employ the use of a lien as part of their collection practices. I agree that I am fully responsible for balances not covered by lien payments and guarantee payment of my bill in full regardless of lien law limitations.

CANCELLATION FEE: I agree to pay a $50.00 cancellation fee for a massage appointment no-show or a massage appointment cancelled less than 24 hours in advance. This fee is not covered by any insurer and is the patient's responsibility.

REBILLING FEE: I agree to pay a $10 per month statement fee for any unpaid patient balances (i.e. co-payments, deductibles, and other amounts not covered by insurance) that are billed to me more than once.

Consent for treatment: I hereby authorize the doctors at Alpine Chiropractic Center, PC. and whomever they may designate as their assistants to administer x-rays, chiropractic adjustments, other chiropractic procedures, various modes of physical therapy, and massage, as they so deem necessary. I have read, fully understood and signed the additional Informed Consent for treatment.

Privacy: THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. To ensure your privacy, Alpine Chiropractic Center, PC, does not conduct any electronic business transactions. You have a right to view or receive a copy of the information in your medical chart. This information is not disclosed to any other party without your written permission or court documents legally requiring this. From time to time, you may hear patient information within our offices; we ask that you keep it confidential.

I certify that I have read and understood the information above, and that what I have written is true and correct.

Signature of Patient	Date	Parent/guardian signature (if patient is under 18)	Date

Functional Rating Index – Neck/Back

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In order to properly assess your condition, we must understand how much your neck and or back problems have affected your ability to manage everyday activities. As you read the list, **think of yourself *today***. *Please circle the number that **most closely** describes your condition **right now.***

Section 1: Pain Intensity

0	1	2	3	4
No pain	Mild pain	Moderate pain	Severe pain	Worst Possible pain

Section 2: Sleeping

0	1	2	3	4
Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

Section 3: Personal Care (washing, dressing etc.)

0	1	2	3	4
No Pain; no restrictions	Mild pain; no restrictions	Moderate pain, need to go slowly	Moderate pain; need assistance	Severe pain; need 100% assistance

Section 4: Traveling

0	1	2	3	4
No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips

Section 5: Work

0	1	2	3	4
Can do usual work, + unlimited extra work	Can do usual work; no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work

Section 6: Recreation

0	1	2	3	4
Can do all activities	Can do most activities	Can do some activities	Can do a few activities	Cannot do any activity

Section 7: Frequency of Pain

0	1	2	3	4
No Pain	Occasional pain; 25% of day	Intermittent pain; 50% of day	Frequent pain; 75% of day	Constant pain; 100% of day

Section 8: Lifting

0	1	2	3	4
No pain with heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight

Section 9: Walking

0	1	2	3	4
No Pain; any distance	Increased pain after 1 mile	Increased pain after ½ mile	Increased pain after ¼ mile	Increased pain with all walking

Section 10: Standing

0	1	2	3	4
No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after ½ hour	Increased pain with any standing

Patient Name____________________________ Patient Signature____________________________ Date________________

History

When did condition(s) begin and how? ______________________________

____

____

List your current condition(s) or symptom(s) in the order of decreasing severity:

1. ______________________________

   Duration: ______________ Frequency: ______________

2. ______________________________

   Duration: ______________ Frequency: ______________

3. ______________________________

   Duration: ______________ Frequency: ______________

4. ______________________________

   Duration: ______________ Frequency: ______________

5. ______________________________

   Duration: ______________ Frequency: ______________

6. ______________________________

   Duration: ______________ Frequency: ______________

7. ______________________________

   Duration: ______________ Frequency: ______________

8. ______________________________

   Duration: ______________ Frequency: ______________

Prior Medical Care:

Please list all surgeries and approximate dates:

Date	Type of Surgery	Post-operative complication(s)

Of the following diagnostic procedures, please indicate those you have undergone:

Study	No	Yes	Date	Results
Reg. Spine x-rays				
MRI				
CT Scan				
Bone Scan				
EMG				
Nerve Block				
Other: ________	N/A			

History of fractures:

Date	Fracture	Complications

LIFESTYLE HISTORY:

Do you (or have you) ever smoked cigarettes, cigars, a pipe, or used chewing tobacco? Yes / No

If yes, how many years? ________ If yes, what is the frequency during an average day? ________

If yes, what age were you when you quit? _______ ☐ N/A because I have not quit.

Do you drink alcoholic beverages? Yes / No

If yes, for how many years? ________ If yes, average number of drinks per week: ____________

Have you ever used alcohol to control your pain? Yes / No

HISTORY OF PREVIOUS CONDITION(S):

Prior to this current condition(s), have you ever had similar condition that required professional help? Yes / No

If yes, briefly explain: ____

Other than this current condition, have you ever had any previous neck or back symptoms, that required professional help? Yes / No

If yes, briefly explain: ____

____

(continued on next page)

OCCUPATIONAL HISTORY:

How physically demanding is your job?

- ☐ Very heavy (frequently lifting 100 or more pounds
- ☐ Heavy (frequently lifting 60 – 100 pounds)
- ☐ Moderate (frequently lifting 30 – 60 pounds)
- ☐ Light (frequently lifting 10 – 30 pounds)
- ☐ Sedentary (essentially no lifting)

Your work status at time of onset of this condition(s)

- ☐ Regular duties (full time)
- ☐ Temporary light duties
- ☐ Permanent light duties
- ☐ Not currently in work force
- ☐ On disability or time loss
- ☐ On public assistance

How satisfied are you with your job?

- ☐ Very satisfied
- ☐ Satisfied
- ☐ Dissatisfied
- ☐ It is the worst job I have had

When was the last time you worked?

- ☐ Today
- ☐ Yesterday
- ☐ Last week
- ☐ Last month
- ☐ Last year

Other: ______________________

Has your employer treated you fairly? Yes / No

FEMALES ONLY:

Indicate all that apply:

- ☐ Vaginal bleeding other than time of menstrual cycle
- ☐ Obstetrician/gynecological exam within the last two years.
- ☐ Currently having painful menstrual cycles that interfere with daily life
- ☐ Back pain increases with menstrual cycles.
- ☐ I have other menstrual problems
- ☐ I may be or I am currently pregnant. Approximate due date: ______________________

Signature: ____
(Please sign whether pregnant or not)

Alpine Chiropractic
Informed Consent

Every type of health care is associated with some risks of potential problems. This includes chiropractic health care. We want you to be informed about potential problems associated with chiropractic health care before consenting to treatment.
Chiropractic adjustments are the moving of bones with the doctor's hands or with the use of a mechanical device or machine. Frequently adjustments create a "pop" or "click" sound/sensation in the area being treated. In this office we used trained staff personnel to assist the doctor with massage therapy. Occasionally when your doctor is unavailable, another clinic doctor will treat you on that day.
Neck Artery Dissector and Stroke: Dissection is when the lining of a neck artery breaks down. This might happen spontaneously, or from an injury, or from a trivial movement (hair shampooing, checking traffic, looking up, etc.). Dissections tend to cause neck pain and/or headache. Dissections may form a clot that can dislodge and interfere with blood flow. If that happens, it is called a stroke. Stroke means that a portion of the brain or spinal cord does not receive enough oxygen from the blood stream. The results can be temporary or permanent dysfunction of the brain, with a very rare complication of death. The literature is mixed or uncertain as to whether chiropractic adjustments are associated with stroke or not. Recent evidence suggests that it is not (2008, 2015, 2016, 2019) although the same evidence often suggests that the patient may be entering the chiropractic office for neck pain/headaches or other symptoms that may in fact be a spontaneous dissection of a neck artery. There are no in-the-office tests to diagnose the spontaneous neck artery dissection (2020) but they might be detectable with advanced imaging (CT/MRI, etc.). If we think you may be suffering from a spontaneous neck artery dissection and/or associated stroke, you will be immediately referred to emergency services. Anecdotal cases suggest that chiropractic adjustments may be associated with dissection and/or stroke that arise from the vertebral artery: this is because the vertebral artery is located inside the neck vertebrae. The adjustment that is suggested to increase the strain on the vertebral artery is called the "extension-rotation-thrust atlas adjustment". We do not do this type of adjustment on patients. Other types of neck adjustments may also potentially be related to vertebral artery strokes, but no one is certain. It is estimated that the incidence o this type of stroke ranges between 1 per every 400,000-3,000,000 neck adjustments. If you experience any of the "5 Ds and 3 Ns" before, during, or after an adjustment, tell us immediately, and if we can't be reached, go to the emergency department immediately. Two other potential problems that are not quantifiable because they are extremely rare and have no association with chiropractic adjusting are carotid artery injury, and spinal dural tear resulting in a leak of cerebral spinal fluid.
Disc Herniations: Both back and neck disc herniations may create pressure on the spinal nerve on the spinal cord. They are frequently successfully treated by chiropractors and chiropractic adjustments, traction, etc. Occasionally chiropractic treatment (adjustments, traction, etc.) may aggravate a disc/nerve problem and rarely surgery may become necessary for correction.
Cauda Equina Syndrome: Cauda Equine Syndrome occurs when a low back disc problem puts pressure on the nerves that control bowel, bladder, and sexual function. Representative symptoms include leaky bladder, or leaky bowels, or loss of sensation (numbness) around the pelvic sexual area (the saddle area), or the inability to start/stop a bowel movement. Cauda Equina Syndrome is a medical emergency because the nerves that control these functions can permanently die and those functions may be lost or compromised forever. The standard approach is to surgically decompress the nerves, and the window to do so may be as short as 12-72 hours. If you have any of these symptoms, tell us immediately, and if we can't be reached go to the emergency department immediately.
Soft Tissue Injury: Soft Tissues primarily refer to muscles and ligaments. Muscles move bones, and ligaments limit joint movement. Rarely a chiropractic adjustment, traction, massage therapy, etc., may overstretch some muscle or ligament fibers. The result is a temporary increase in pain and necessary treatments for resolution, but there are no long-term effects for the patient.
Rib and other Fractures: Rarely a chiropractic adjustment will crack a rib bone, and this is referred to as a fracture. We adjust all patients very carefully, and especially those who have known osteoporosis. Other fraction locations are extremely rare but possible, especially those aged over 65 years and/or on steroid drugs.
Heat and Ice: We recommend both heat and ice for home care on occasion. Everyone's skin has different sensitivities, and rarely, both heat and ice can burn or irritate the skin. The result is a temporary increase in pain, and there may even be some blistering of the skin. Never put an ice pack directly on the skin. Always have an insulating towel between.
Soreness: It is common for chiropractic adjustments, traction, massage therapy, exercise, etc., to result in a temporary increase in soreness in the region being treated. This is nearly always a temporary symptom that occurs while your body is undergoing therapeutic change. It is not dangerous, but please do tell your doctor about it.
Other problems: There may be other problems or complications that might arise from the chiropractic treatment other than those noted above. The other problems or complications occur so rarely that it is not possible to anticipate and/or explain them all in advance of treatment. Chiropractic is a system of healthcare delivery, and therefore, as with any healthcare delivery system, we cannot promise a cure for any symptom, disease, or condition as a result of treatment in this clinic. We will always give you our best care, and if results are not acceptable, we will refer you to another provider whom we feel will assist your situation. Alternatives to chiropractic care include do nothing, drugs, surgery, acupuncture, massage, etc. Risks from these procedures should be addressed with that provider.
Massage: I understand the massage given here is for the purpose of relief from muscular tension or spasm, and for increasing circulation. Understand the massage practitioner does not diagnose illness, disease, or other physical or mental disorder. As such, the therapist does not prescribe medical treatment or pharmaceuticals, nor perform spinal manipulations. I understand massage is not a substitute for medical examination and diagnosis, and that it is recommended to see physician for any physical ailments I may have. Because the massage practitioner must be aware of existing conditions, I have stated all my known medical conditions and take it upon myself to keep the practitioner updated on my physical, mental, and emotional health.

I have read and fully understand the above statements, and therefore, accept chiropractic care on this basis.
I agree that financial responsibility for my treatment is ultimately my own.
I agree that a fee may be charged if I cancel my appointment less than 24 hours before it begins.

Signature: ____ Date:______________________
Printed Name:____

Consent to evaluate and adjust a minor child

Parent/Guardian Signature:____D.O.B.______________

I, the above signed, being the parent or legal guardian of __________________________have fully read the above Informed Consent and hereby grant permission for my child to receive chiropractic care.

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NOTICE OF PRIVACY PRACTICES

Breach Notification: In the case of a breach of unsecured protected health information, we will notify you unless after completing a risk analysis as dictated by law it is determined that there is a "low probability of PHI compromise". Notification will be by either email or phone.

Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority, or attorney, provided that a workforce member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are not potentially endangering one or more patients, workers, or the public.

Acknowledgement of Review and Receipt of Notice of Privacy Practices

- ❑ I hereby acknowledge receipt of a copy of this Notice of Privacy Practices.

Signed: ______________________________ Print Name: ______________________________

Effective Date: ______________ If not signed by patient, indicate relationship: ______________________________

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Consent to receive SMS

By signing below and supplying my phone number, email address, and any other personal contact information, I authorize Alpine Chiropractic Center to use SMS messaging to communicate with me regarding scheduled or missed appointments, patient waitlist and recall, account balance notifications and statements, as well as other Protected Health Information. I authorize Alpine Chiropractic Center to use an automated outreach and messaging system for certain reminders and notifications. I consent to receive multiple and/or recurring SMS messages and understand that messaging frequency varies and messaging and data rates may apply.

For Text Message Services, text HELP to the sending number with questions and text STOP to that number to Opt-out. Your Opt-out request may generate a confirmation text.

Signature:____ Date:____________

Printed Name:____