Spring into Life
CHIROPRACTIC

Travis Diederich. D.C.
903 South 17th Ave. Suite D
Wausau, WI 54401
715.845.6800
www.MyWausauChiropractor.com

Adult Intake Form

Personal Information

Date: _____

Name: _____ Date of Birth: ___/___/___ Age: _____ Male / Female

Address: _____
Number & Street City State Zip

Phone (H): _____ (Cell): _____ (Work): _____

E-mail Address: _____ Best way to contact you: _____

Work Status: ☐ Full-time ☐ Part-time ☐ Self Employed ☐ Unemployed ☐ Retired

Occupation: _____ Employer: _____

Marital Status: Single / Married / Divorced / Widowed / Other Spouses Name: _____

How many children do you have? _____ Ages: _____

Who may we thank for referring you or how did you hear about us? _____

Reason for Seeking Care

What is your reason for seeking care at Spring into Life Chiropractic? _____

_____

When did this begin? (If applicable) _____

Are there any major injuries and/or surgeries we should know about? _____

_____

What is this affecting that is MOST important in your life? (List all that apply) _____

_____

Have you seen any other providers for this condition? _____

Have you seen a chiropractor before? Yes / No How long ago? _____

Reason for change? _____

What health goal, if you were to complete or accomplish it, would have the greatest impact on your life?

_____

_____

Health Summary

Please ☑ check ALL symptoms or conditions you have ever had, even if they don't seem related to your current problem.

- ☐ Headaches
- ☐ Dizziness
- ☐ Allergy/Sinus Issues
- ☐ Fatigue
- ☐ Vision Problems
- ☐ Ringing in Ears
- ☐ Hearing Problems
- ☐ Stiff Neck
- ☐ Pins & needles in arms
- ☐ High Blood Pressure
- ☐ Heart Conditions
- ☐ Chest Pain
- ☐ Middle Back Pain
- ☐ Asthma
- ☐ Gallbladder Issues
- ☐ Diabetes
- ☐ Ulcers
- ☐ Liver Problems
- ☐ Kidney Problems
- ☐ Heartburn / Indigestion
- ☐ Constipation
- ☐ Diarrhea - Gas Pain
- ☐ Bladder Problems
- ☐ Low Back Pain
- ☐ Pain/Numbness in legs
- ☐ Reproductive Problems
- ☐ Fever/Sweats/Chills
- ☐ Cancer
- ☐ Anxiety/Depression
- ☐ Rashes/Eczema
- ☐ Cold Hands/Feet
- ☐ Loss of sleep
- ☐ Arthritis

For women:

- ☐ PMS
- ☐ Mood swings
- ☐ Menstrual pain
- ☐ Taking birth control
- ☐ Currently pregnant

☐ Any additional concerns? _____

Medications

Please list ALL medications you are taking:

- ☐ Cholesterol: _____
- ☐ Blood Pressure: _____
- ☐ Blood Thinner: _____
- ☐ Pain Meds: _____
- ☐ Depression/Anxiety: _____
- ☐ Diabetes Meds: _____
- ☐ Thyroid Meds: _____
- ☐ Other: _____

Family Health History

At our office we are not only interested in your health, but also the health & wellness of your family and loved ones. Please list any health conditions or concerns they may have:

Children: _____

Spouse: _____

Mother: _____

Father: _____

Siblings: _____

Others: _____

Authorization for Care

I hereby authorize a complete chiropractic evaluation and treatment as deemed appropriate. I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any staff member of Spring into Life Chiropractic responsible for any errors or omissions that I may have made in the completion of this form. I understand that any fee for service rendered is due at the time of service.

Patient or Guardian Signature: _____ Date: _____

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, strokes, dislocations, strains, and sprains. 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.

Arterial dissections occur in 3-4 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 chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events/ per one million persons/year and risk of death has been estimated as 104 per one million users.

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.

Patient Name: _____

Patient or Guardian Signature: _____ Date: _____

Notice of Privacy Practices (HIPAA)

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 (PHI) we encourage you to read the NOTICE PRIVACY PRACTICES (HIPAA) that is available to you at the front desk upon request 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 and the billing service utilized by Spring into Life Chiropractic, LLC 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. 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.
5. For your security and right to privacy, all staff has been trained in the area of 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.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. 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.

Our office reserves the right to amend the terms of this HIPAA NOTICE. I have read and understand how my Patient Health Information (PHI) will be used and I agree to these policies and procedures.

Patient Name: _____

Patient or Guardian Signature: _____ Date: _____