Patient Information and Consultation Form

STRIVE
INTEGRATIVE HEALTH

Please fill this out this application entirely and legibly. We need all information for insurance purposes.

Name_____ Nickname_____

Address _____

City _____ State_____ Zip Code _____

Cell Phone _____ Email _____

Birthday _____ Social Security #_____ Marital Status _____

Emergency Contact and Relation _____ Contact's Cell Phone _____

Occupation_____ Retired? Yes No

Do you have insurance? Yes No **FOR WOMEN ONLY**: Are you pregnant? Yes No

Who referred you to, or how did you hear about, our office?_____

Review of Symptoms

Please check all that apply :

- ☐ Foot Pain
- ☐ Hand Pain
- ☐ Low Back Pain
- ☐ Neck Pain
- ☐ Foot Numbness
- ☐ Hand Numbness
- ☐ Diabetes
- ☐ High Cholesterol
- ☐ High Blood Pressure
- ☐ Pacemaker/ Defibrillator
- ☐ Herniated Disc
- ☐ Bulging Disc
- ☐ Spinal Stenosis
- ☐ Degenerative Disc
- ☐ Vascular Problems
- ☐ Leg Pain
- ☐ Plantar Fasciitis
- ☐ Morton's Neuroma
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Arthritis in Hands
- ☐ Arthritis in Feet
- ☐ Implanted Cord/ Bladder Stimulator
- ☐ Sciatica
- ☐ Pinched Nerve
- ☐ Poor Circulation
- ☐ Joint Replacement
- ☐ Foot Surgery
- ☐ Poor Wound Healing
- ☐ Excessive Thirst or Urination

Present Health Conditions

- **In order of importance, list the health problems you are most interested in getting corrected:**

1._____
2._____
3._____
4._____

- **List approximately how long you have noticed these problems:**

1._____
2._____
3._____
4._____

- **Is there a certain time of day any of these problems are better or worse?**

_____
_____
_____

- **List the things you've used for these problems:**

Gabapentin Neurontin Lyrica Cymbalta Physical therapy Pain Medications Aleve Tylenol Ibuprofen Motrin Chiropractic Massage Therapy Injections Creams

- **Is your balance/walking ability affected?**

_____
_____

- **What do you think is causing your problem?**

_____
_____

- **Name of all doctors you have seen for these problems and treatment you received:**

_____
_____

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- **Have your symptoms:** ☐ Improved ☐ Worsened ☐ Stayed the same

List anything that makes your condition worse: _____

_____

List anything that makes your condition better: _____

_____

- **How would you describe the symptoms? Please check ALL that apply**

☐ Aching Pain	☐ Numbness	☐ Hot Sensation	☐ Cramping
☐ Stabbing Pain	☐ Tingling	☐ Throbbing Pain	☐ Swelling
☐ Sharp Pain	☐ Pins &Needles	☐ Dead Feeling	☐ Burning
☐ Tiredness	☐ Heavy Feeling	☐ Cold Hands/Feet	☐ Electric Shocks

- **Is this condition interfering with any of the following?**

☐ Sleep	☐ Work	☐ Daily Activities
☐ Recreational Activities	☐ Walking	☐ Standing

Social History

Do you smoke? Yes ☐ No ☐ If yes, how many cigarettes daily?_____

Do you drink? Yes ☐ No ☐ If yes, how many drinks per week?_____

Do you exercise regularly? Yes ☐ No ☐ If yes, please describe **type and how often:**

_____

Current Pain Levels

How would you rate your pain in the last week?

NO PAIN **1** **2** **3** **4** **5** **6** **7** **8** **9** **10** WORST PAIN POSSIBLE

Previous Health History

This is a confidential record of your medical history and pertinent personal information. The doctor reserves the right to discuss this information with medical and allied health professionals per the informed consent. Copies of this record can only be released with your written authoriza tion, unless you sign here indicating that we can release copies by your verbal request.

Name_____ Signature_____

Please give name, address, and office phone number of your primary care physician.
Name_____ Phone_____ Address_____

Please list any person(s) you would like to grant access to your health file (ex. spouse, children, etc.):

_____

- List **allergies/sensitivities** (medications, foods, etc.):_____
- List **prescription drugs** (or attach a list):_____

_____

- List **nutritional supplements** (or attach a list):_____

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Patient Quality of Life Survey

- **How have you taken care of your health in the past?**

    a. Medications
    b. Emergency Room
    c. Routine Medical
    d. Exercise
    e. Nutrition /Diet
    f. Holistic Care
    g. Vitamins
    h. Chiropractic
    i. Other If Other, (please specify):_____

- **How did the previous method (s) work out for you?**

    a. Bad results
    b. Some results
    c. Great results
    d. Nothing changed
    e. Did not get worse
    f. Did not work very long
    g. Still trying
    h. Confused

- **How have others been affected by your health condition?**

    a. No one is affected
    b. Haven't noticed any problem
    c. They tell me to do something
    d. People avoid me

- **What are you afraid this might be (or beginning) to affect (or will affect)?**

    a. Job
    b. Kids
    c. Future ability
    d. Marriage
    e. Self-esteem
    f. Sleep
    g. Time
    h. Finances
    i. Freedom

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Patient Quality of Life Survey

- **Are there health conditions you are afraid this might turn into?**
    a. Family health problems
    b. Heart disease
    c. Cancer
    d. Diabetes
    e. Arthritis
    f. Fibromyalgia
    g. Depression
    h. Chronic Fatigue
    i. Need surgery

- **Is this condition interfering with any of the following? Sleep Work Daily Activities Recreational Activities Walking Standing Please give examples:**

_____
_____
_____

- **What has that cost you? Time Money Happiness Freedom Sleep Promotion Please give 3 examples:**

_____
_____
_____

- **What are you most concerned with regarding your problem?**

_____
_____

- **Where do you picture yourself being in the next 1-3 years if this problem is not taken care of? Please be specific:**

_____
_____
_____
_____

- **What would be different / better without this problem? Please be specific :**

_____
_____

- **What do you desire most to get from working with us?**

_____
_____

- **What would that mean to you?**

_____
_____

OFFICE POLICY

The following is an explanation of our office policies. We believe that a clear understanding will allow us both to concentrate on the most important issues; regaining and maintaining your health. We will be happy to answer any questions you may have regarding our policies.

Complimentary Consultation: Strive Integrative Health will conduct a "no charge" consultation, or brief conference, with anyone interested in finding out if our services can help them with their individual health problem. There is no charge or obligation in connection with this appointment.

Patient Care Services: Payment arrangements may be made with the office and payments must be made no less than monthly. Please understand that all services rendered to you are charged directly to you and you are responsible for payment, regardless of your insurance coverage. Properly documented auto accident claims are not required to pay at the time of service if appropriate forms are signed.

Our Policy on Health Insurance: Many insurance policies cover care. We are able to file your insurance claim for you and do everything we can to ensure you receive reimbursement. However, we cannot take responsibility for what your health insurance will or will not cover. It is important that you understand that health and accident insurance policies are an arrangement between an insurance carrier and you, the patient, their insured. Furthermore, any amount authorized to be paid directly to Strive Integrative Health will be credited to your account upon receipt.

Identification Policy: Strive Integrative Health requires a copy of photo identification (ex: driver's license, passport, student ID) be on file in order to receive care. Also, we require an electronic photo be taken and placed into your health care chart for verification purposes.

NOTICE OF LIKELIHOOD OF INSURANCE DENIAL OF BENEFITS

I understand that my insurance company may deny payment for the service provided to you for the following reasons: That the particular service is not reasonable and necessary under my insurance companies standards. Please read and sign the bottom of this form acknowledging the following statement:

"I have been informed by my physician that he believes that, in my particular case, my insurance may deny payment for the services identified above, for the reasons stated. If my insurance denies payment I agree to be personally responsible for payment of said services."

ASSUMPTION OF FINANCIAL RESPONSIBILITY

Explanation of benefits disclaimer

I, the undersigned patient, understand that Strive Integrative Health provides insurance billing and insurance benefit verification as a courtesy to their patients. I understand that the service Strive Integrative Health provides for verification of insurance coverage is in no way a promise of payment by my insurance company. If my insurance company denies my claim(s) for any reason, or misquotes my benefits, the balance of my account will be billed to me and due to the clinic. It is the policy of Strive Integrative Health to never enter into a dispute with your insurance company for any reason. I, the undersigned patient, completely understand the insurance services provided to me regarding my insurance coverage as stated above. I under stand that my signature below serves as a "signature on file" to bill the above insurance company and allows this clinic to accept assignment of insurance benefits. I understand the above "Benefits Disclaimer" and my financial responsibilities to any services rendered by this clinic. I understand that Strive Integrative Health may have a contract with my insurance company that allows only copays to be collected at time of service. By signing this form, I am agreeing to pay any copay, deductible and coinsurance at time of service. This may offer a reduced fee for paying at the time of service rendered.

Signature _____ Date_____

Printed Name_____

INFORMED CONSENT

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 referred to as “informed consent”. This involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with 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.

Neuropathy care treatment may involve in-office and/or at-home treatments. Treatments may include but are not limited to: vibration therapy, low level light therapy, myoacoustic treatment, spinal decompression and/or nerve re-education treatments with a Rebuilder. Adverse responses to treatment are incredibly rare when treatment is done as prescribed.

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, 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. Patients who experience this condition often, but not always, present to their providers with neck pain and headaches. 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 1,219 events/ per one million persons/year and risk of death has been estimated as 104 per one million users. Other treatments for neck pain and headaches you may have tried 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. It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure.

Signature _____ Date_____

Printed Name_____