CAPITAL CHIROPRACTIC & REHABILITATION CENTER
In pursuit of your best life

Confidential Patient Information

Capital CRC, PLLC
601 E. Locust St. Ste 102
Des Moines, IA 50309
(515) 421-4018 Phone
(515) 421-4019 Fax
www.CapitalChiroDSM.com

Date:_____/_____/_____

Patient's Full Name _____

Mailing Address:_____ City:_____ State:_____ Zip:_____

Cell Phone: _____-_____-_____ Birthdate: _____/_____/_____

E-Mail: _____ How would you prefer to receive appointment reminders? ☐ Email ☐ Txt to Cell

If text to cell is preferred, please provide the name of your cell phone provider: _____

☐ Male ☐ Female ---------- ☐ Married ☐ Partner ☐ Single ☐ Separated ☐ Widowed

Spouse's Name:_____ Number of Children/Ages_____

How did you find us?

☐ Existing Patient
Name:_____
☐ Physician
Name:_____
☐ Friend
Name:_____

☐ Clinic Website
☐ MPI Website
☐ Graston Website
☐ Active Release Tech. Website
☐ Other Website:_____

☐ Chamber of Commerce (EDM/SDM, Downtown, WS)
☐ Google:_____
☐ Social Media – Facebook, Twitter, Instagram
☐ Yelp/Google Plus/

☐ If referred by a person, is it okay for us to use your name when thanking them for referring you? ☐ Yes ☐ No

Social Security # _____ - _____ - _____

Status: ☐ Employed ☐ Full Time Student ☐ Part Time Student ☐ Retired ☐ Unemployed Occupation:_____

Place of Employment _____ Work Address:_____ _____

Emergency Contact:_____ Relationship:_____ Phone: _____-_____-_____

Previous Chiropractic Care: ☐ Yes ☐ No If Yes, for what Problem: _____

Previous Chiropractor's Name _____ City: _____ State:_____

Is Today's Visit Due To A Work Related Injury: ☐ Yes ☐ No **Is Today's Visit Due To An Auto Accident:** ☐ Yes ☐ No
(If yes to either questions above, please check with receptionist, additional information is needed)

Insurance Policy Information –

Policy Name_____ID # _____ Group #_____

Full Name (If not you) _____Birthdate: _____/_____/_____ Cell Phone: _____

Mailing Address:_____ City:_____ State:_____ Zip:_____

Authorization and Assignment

In consideration of your undertaking to care for me, I agree to the following:

1. You are authorized to release **any information** you deem appropriate concerning my physical or emotional condition, health history, or billing and payment history to any insurance company, attorney, or adjuster for the purpose of any claim for reimbursement of charges incurred by me.
2. I authorize my attorney and/or any insurance company to make **direct payment to you** of settlement proceeds.
3. I hereby assign and transfer to you the cause of action that exists in my favor against any insurance company obligated by contractual agreement to make payment to me or to you for the charges made for your service. I authorize you to prosecute said action either in my name. I further authorize you to compromise, settle, or otherwise resolve said claim as you see fit. I understand that whatever amounts you do not collect from insurance companies, whether it be all or part of what was due, **I personally owe to you**.
4. I further agree that this Authorization and Assignment is irrevocable until all moneys owed to you (Capital Chiropractic and Rehabilitation Center, PLLC) are **paid in full**.

Patient Signature:_____ **Date:**_____/_____/_____

Dear Patient: Please complete this form and questionnaire. If you need assistance, please ask. Your answers will help us determine if chiropractic care can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. THANK YOU.

Primary Complaint: _____Secondary Complaint: _____

Date of Injury:_____ How did your symptoms begin? (i.e. Lifting, Driving, Sports etc.)_____

In the past have you had anything similar to this? ☐ Yes ☐ No Please explain_____

Is your Pain:	**Was the Onset:**	**Pain is aggravated by:**	**Pain is improved by:**
☐ Increasing ☐ Decreasing ☐ Not Changing ☐ Varies	☐ Gradual ☐ Sudden	☐ Walking ☐ Lifting ☐ Sitting ☐ Bending ☐ Riding in a car ☐ Stretching ☐ Standing ☐ Twisting ☐ Other_____	☐ Medication ☐ Chiropractic Adjustment ☐ Rest ☐ Exercise ☐ Therapy ☐ Other_____

When are your symptoms worse?

☐ Stay the same all day ☐ Worse in the morning ☐ Worse in the afternoon ☐ Worse at night ☐ Worse during provocative activities

Family Doctor / Primary Care Physician (PCP)?_____

It is our policy to keep your family doctor and/or referring physician informed regarding your care in this office.

☐ Yes ☐ No Is it okay to inform your PCP? If Yes please specify name and address_____

☐ Yes ☐ No Is pain affecting your ability to work or be active?

What specific activities are limited by your symptoms?_____

☐ Yes ☐ No Any change in bowel or bladder (bathroom) function? If Yes explain:_____

☐ Yes ☐ No Any fever or chills? If Yes explain:_____

☐ Yes ☐ No Any dizziness associated with symptoms? If Yes explain:_____

☐ Yes ☐ No Have you experienced any unexplained weight loss, fatigue, or blood loss? If Yes explain:_____

☐ Yes ☐ No Are your complaints affecting your sleep? If Yes explain:_____

☐ Yes ☐ No Have you had any tests for this complaint? (i.e. x-rays, MRI, CT) If Yes explain:_____

☐ Yes ☐ No Any recent falls / accidents / surgeries / broken bones? If Yes explain:_____

☐ Yes ☐ No Have you seen any other physicians in the past 6 months? If Yes explain:_____

☐ Yes ☐ No Have you had any prior treatment for this complaint? If Yes, who?_____

What treatment?_____

☐ Yes ☐ No Have you been in the hospital or had surgery for any reason? If Yes explain:_____

☐ Yes ☐ No Have you ever been in an accident? If Yes explain:_____

What **non-prescription** medication are you taking?

☐ Tylenol ☐ Aspirin
☐ Ibuprofen ☐ None
☐ Other_____

How often?
☐Daily ☐Weekly ☐Other:_____

What **Prescription** medication are you taking?

☐ Anti-inflammatory ☐ Birth Control Pill ☐ Diet Pills
☐ Pain Killers ☐ Cholesterol Meds ☐ Anxiety/Depression
☐ Muscle Relaxers ☐ Insulin ☐ HRT
☐ Blood Pressure Meds ☐ Tranquilizers ☐ Sleeping Aid

☐ Other_____ ☐ None
Specific names if possible:_____

☐ Yes ☐ No Do you smoke? If Yes how much?:_____

If you have quit smoking, when did you quit?_____

☐ Yes ☐ No Do you consume alcohol?

☐ Yes ☐ No Do you exercise? If Yes, what is your routine?_____

☐ Yes ☐ No Do you have allergies? If Yes, please list them?_____

In general, would you say your health right now is… ☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor

What type of care are you interested in: ☐ Pain relief ☐ Healing of current condition ☐ Improved Athletic Performance ☐ Injury Prevention

FAMILY HISTORY AND HEALTH STATUS: list any diseases, disorders, or major illnesses. If deceased, from what?

Mother:_____ Father:_____

Brother(s):_____ Sister(s):_____

Other:_____ Other:_____

Review of Systems:

Have you had trouble with any of the following:

Cardiovascular:			No
	Present	Past	No
Poor Circulation			
High Blood Pressure			
Aortic Aneurism			
Heart Disease			
Heart Attack			
Chest Pain			
High Cholesterol			
Pace Maker			
Jaw Pain			
Irregular Heartbeat			
Swelling of Legs			

Genitourinary:			No
	Present	Past	No
Kidney Disease			
Lower Side Pain			
Burning Urination			
Frequent Urination			
Blood in urine			
Kidney Stone			

Hematologic/lymphatic:			No
	Present	Past	No
Hepatitis			
Blood Clots			
Cancer			
Easy Bruising			
Easy Bleeding			
Fevers/Chills/Sweats			

Neurologic:			No
	Present	Past	No
Stroke			
Seizures			
Head Injury			
Brain Aneurysm			
Numbness			
Severe Headaches			
Pinched Nerves			
Parkinson's Disease			
Carpal Tunnel			
Spinning/Balance			

Respiratory:			No
	Present	Past	No
Asthma			
Tuberculosis			
Shortness of Breath			
Emphysema			
Cold/Flu			
Cough/Wheezing			

Ears/Nose/Throat:			No
	Present	Past	No
Dizziness			
Hearing Loss			
Sinus Infection			
Nosebleed			
Sore Throat			
Difficulty Swallowing			
Bleeding Gums			

Eyes:			No
	Present	Past	No
Glaucoma			
Double Vision			
Blurred Vision			

Integumentary:			No
	Present	Past	No
Skin Ulcers			
Skin Disease			
Eczema			
Psoriasis			
Rashes			

Psychiatric:			No
	Present	Past	No
Depression			
Anxiety Disorder			
Unusual Stress			

Constitutional:			No
	Present	Past	No
Weight Loss/Gain			
Energy Level Problem			
Difficulty Sleeping			

Allergic/Immunologic:			No
	Present	Past	No
Hives			
Immune Disorder			
HIV/AIDS			
Allergy Shots			
Cortisone Use			

Gastrointestinal:			No
	Present	Past	No
Gallbladder Problems			
Bowel Problems			
Constipation			
Liver Problems			
Ulcers			
Diarrhea			
Nausea/Vomiting			
Bloody Stools			
Poor Appetite			

Musculoskeletal:			No
	Present	Past	No
Gout			
Arthritis			
Joint Stiffness			
Muscle Weakness			
Osteoporosis			
Broken Bones			
Joints Replaced			

Endocrine:			No
	Present	Past	No
Thyroid Disease			
Diabetes			
Hair Loss			
Menopausal			
Menstrual Problems			

INFORMED CONSENT

Medical doctors, chiropractic doctors, osteopaths, and physical therapists who perform manipulation are required by law to obtain your informed consent before starting treatment.

I_____, do hereby give my consent to the performance of conservative noninvasive treatment to the joints and soft tissues. I understand that the procedures may consist of manipulations/adjustments involving movement of the joints and soft tissues. Physical therapy and exercises may also be used. Although spinal and extremity manipulation/adjustment is considered to be one of the safest, most effective forms of therapy for musculoskeletal problems, I am aware the there are possible risks and complications associated with these procedures as follows:

Soreness/Bruising: I am aware that like exercise it is common to experience muscle soreness and occasionally bruising in the first few treatments.

Dizziness: Temporary symptoms like dizziness and nausea can occur but are relatively rare.

Fractures/Joint Injury: I further understand that in isolated cases underlying physical defects, deformities or pathologies like weak bones from osteoporosis may render the patient susceptible to injury. When osteoporosis, degenerative disc, or other abnormality is detected, this office will proceed with extra caution.

Stroke: Although strokes happen with some frequency in our world, strokes from chiropractic adjustments are rare. I am aware that nerve or brain damage including stroke is reported to occur once in a million to once in ten million treatments. To put these occurrences in perspective, once in a million is about the same chance as get-ting hit by lightning. Once in ten million is about the same chance as a normal dose of aspirin or Tylenol causing death. The

PhysioTherapy Burns: Some of the therapies used in this office generate heat and may rarely cause a burn. Despite precautions, if a burn is obtained, there will be a temporary increase in pain and possible blistering. This should be reported to the doctor.

Dry Needling and/or Chiropractic Acupuncture adverse reactions include bruising, numbness or tingling near the needling sites, dizziness or fainting. More rare events include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is a possible risk, though the clinic uses sterile disposable needles and maintains a clean and safe environment.

Tests have been or will be performed on me to minimize the risk of any complication from treatment and I freely assume these risks.

TREATMENT RESULTS

I also understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasm. However, I appreciate there is no certainty that I will achieve these benefits. I realize that the practice of medicine, including chiropractic, is not an exact science and I acknowledge that no guarantee has been made to me regarding the outcome of these procedures. I agree to the performance of these procedures by my doctor and such other persons of the doctor's choosing.

ALTERNATIVE TREATMENTS AVAILABLE

Reasonable alternatives to these procedures have been explained to me including rest, home applications of therapy, prescription or over-the-counter medications, exercises, physical therapy and possible surgery.

Medications: Medication can be used to reduce pain or inflammation. I am aware that long-term use or overuse of medication is always a cause for concern. Drugs may mask pathology, produce inadequate or short-term relief, undesirable side effects, physical or psychological dependence, and may have to be continued indefinitely. Some medications may involve serious risks.

Rest/Exercise: It has been explained to me that simple rest is not likely to reverse pathology, although it may temporarily reduce inflammation and pain. The same is true of ice, heat or other home therapy. Prolonged bed rest contributes to weakened bones and joint stiffness. Exercises are of limited value but are not corrective of injured nerve and joint tissues.

Surgery: Surgery may be necessary for joint instability or serious disc rupture. Surgical risks may include unsuccessful outcome, complications, pain or reaction to anesthesia, and prolonged recovery.

Non-treatment: I understand the potential risks of refusing or neglecting care may include increased pain, scar/adhesion formation, restricted motion, possible nerve damage, increased inflammation, and worsening pathology. The aforementioned may complicate treatment making future recovery and rehabilitation more difficult and lengthy.

I have read or had read to me the above explanation of chiropractic treatment. Any questions I have had regarding these procedures have been answered to my satisfaction PRIOR TO MY SIGNING THIS CONSENT FORM. I have made my decision voluntarily and freely.

To attest to my consent to these procedures, I hereby affix my signature to this authorization for treatment.

Signature of Patient:_____ Date:_____

Signature of Parent or Guardian:_____ Date:_____
(if a minor)

Signature of Witness:_____ Date:_____

Financial/Privacy Policy and Disclaimer

Collection of Patient Balance

- Payment is expected at the time of service.
- Your insurance company can and will be billed, determined by your preference and our current status as in-network or out-of-network with that company. We cannot guarantee your coverage, even if the office attempts to confirm your benefits and eligibility. Final approval of coverage is based on the explanation of benefits after the claim has been filed.
- Any balance remaining after insurance benefits are obtained is the responsibility of the patient. Any non-covered services are the responsibility of the patient at the rate determined by in-network or out-of network rates as determined by the insurance company's explanation of benefits.
- If payment is not rendered at the time of service, the patient is expected to remit payment within 30 days of the patient visit.
- All balances remaining unpaid after 30 days may be turned over to a collection agency.
- Please know that it is your responsibility to understand your insurance policy and beware of intricacies of treatment coverage. Unfortunately, we cannot guarantee exactly what your coverage may or may not be.

Returned Checks

- It is our policy to collect $25.00 for checks that are returned to us. This is to cover any fees that apply from the transaction.

Appointments

- If unable to keep an appointment, as a courtesy to our staff and other patients, please give 24-hour notice. Capital Chiropractic and Rehabilitation Center will offer a courtesy two missed appointments without adequate notice. **After two (2) missed/canceled visits without 24-hour notice, the patient will be charged $50.00 for each visit that is missed.** The patient will be responsible for payment.

Financial Policy Questions

- We are happy to address questions regarding you account at any time. Please direct accounting questions to our billing administrator, Chris LoRang or Natalie Clark.

HIPAA Privacy Policy

- Attached to the patient information packet at the back of these forms is the HIPAA Notice of Privacy Practices Policy for you**.** By signing below, the patient acknowledges that he/she has received the HIPAA Privacy Policy and that he/she understands and will comply with our financial policies.

Designation of Authorized Representative

- I do hereby designate Capital Chiropractic and Rehabilitation Center to the full extent permissible under the Employee Retirement income Security Act of 1974 ("ERISA") and as provided in 29 CFR 2560-503-1(b)4 to otherwise act on my behalf to pursue claims and exercise all rights connected with my employee health care benefit plan, with respect to any medical or other health care expense(s) incurred as a result of the services I receive from Capital Chiropractic and Rehabilitation Center . These rights include the right to act on my be-half with respect to initial determinations of claims, to pursue appeals of benefit determinations under the plan, to obtain records, and to claim on my behalf such medical or other health care service benefits, health care benefit plan reimbursement and to pursue any other applicable remedies.

IRREVOCABLE Power of Attorney

- I do hereby authorize Capital Chiropractic and Rehabilitation Center to act on my behalf to pursue claims and exercise all rights in order to collect payments with respect to any medical or other health care expense(s) incurred as a result of the services I receive from Capital Chiropractic and Rehabilitation Center.

_____ _____

Patient Signature **Date**

RELEASE OF PROTECTED HEALTH INFORMATION

I, _____, give my consent to allow the transfer and/or discussion of my protected health information to be released to this office. I understand that as a patient, my health information is confidential, and will be treated as such by this office, Capital Chiropractic and Rehabilitation Center, PLLC. I understand that any information collected by this office will be for the benefit of care provided, and will remain confidential between this office and the providing practitioner.

To attest to my consent to the release of my information, I hereby affix my signature to this authorization.

Signature of Patient:_____ Date:_____

Signature of Parent or Guardian:_____ Date:_____
(if a minor)

Signature of Witness:_____ Date:_____