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:______________
☐ Provider
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 Reviews
☐ Google Reviews

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

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

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)

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	☐ Gradual	☐ Walking	☐ Lifting	☐ Medication	☐ Chiropractic Adjustment
☐ Decreasing	☐ Sudden	☐ Sitting	☐ Bending	☐ Rest	
☐ Not Changing		☐ Riding in a car	☐ Stretching	☐ Exercise	
☐ Varies		☐ Standing	☐ Twisting	☐ Therapy	
		☐ Other_____________________		☐ 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

Please list Names and Dosages of all current medications:

____ ________________________________

____ ________________________________

____ ________________________________

____ ________________________________

☐ Yes ☐ No Do you use tobacco? ☐ Smoke? ☐ Chewing Tobacco How Much?___________________________

If you have quit using tobacco, when did you quit?____

☐ Yes ☐ No Do you consume alcohol? If so, how much?____

☐ 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:____

Expectations for Care

We want to help you meet your health care goals and we also want to meet your expectations. Let us know about past clinical experiences you wish to avoid or replicate.

____

____

____

____

Name________________________Date_________

Health and Wellness Goals

Please share your health goals so we can help you *in pursuit of your best life*.

In the next 4-6 weeks, I'd like to...

Examples: Play tennis without elbow pain and decrease neck pain at work.

1.____

2.____

In the next year, I'd like to...

Examples: Lose 20 pounds by my birthday and train for a marathon.

1.____

2.____

Patient Specific Functional Scale

Please list three activities that are currently limited because of your symptoms and please rate them on a scale of 0-10 (**0 being unable** to perform activity and **10 being able** to perform activity at same level as before injury)

1.____Rating (0-10):____________________

2.____Rating (0-10):____________________

3.____Rating (0-10):____________________

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 that 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 getting hit by lightning. Once in ten million is about the same chance as a normal dose of aspirin or Tylenol causing death.

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.

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 Treating Clinician after any questions have been answered:____________________________ Date:______________

Financial/Privacy Policy and Disclaimer

Returned Checks: It is our policy to collect $25.00 for returned checks. This is to cover any fees that apply from the transaction.

Financial Policy Questions: We are happy to address questions regarding your account at any time. Please direct account questions to our billing administrator.

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, you acknowledge that you have received the HIPAA Privacy Policy and that you understand and will comply with our financial policies.

Collection of Patient Balance

*****Please initial the following to acknowledge that you have read each statement**.

______**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 our 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.

______ **It is the patient's responsibility to understand his/her insurance policy and the intricacies of coverage**. Capital Chiropractic cannot guarantee exact details at any given time.

______ If unable to make your appointment, please notify our office at least 24 hours' notice out of respect and courtesy to other patients. **After two (2) missed/cancelled visits without 24 hours' notice, you will be charged $50.00 for each visit that is missed.** You will be responsible for this payment.

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 behalf 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.

- 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.

Signature of Patient:____ 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.
RPHI expires 3 years after date of signature below.

Signature of Patient:____ Date:______________________________

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