Alternative Health Care Center of the Black Hills

Name: Today's Date:

Mailing Address:

City: State: Zip Code:

Mobile Phone: Home Phone: Work Phone:

Date of Birth: Age: Marital Status:

Drivers License #: SSN: Spouse's Name:

Gender: ☐ M ☐ F E–mail (newsletters):

Patient's Employer/Business: Occupation:

Emergency Contact Person: Phone:

Known Allergies: Are you Pregnant? ☐ Y ☐ N

Previous Chiropractic Care? ☐ Y ☐ N If yes, date of last appointment:

Present Complaint(s):

When did it begin? Is it getting: ☐ better ☐ worse ☐ staying the same

Please rate your pain intensity on a scale of 0-10 (0=no pain, 10=most severe):

I have difficulty with: ☐ lifting ☐ walking ☐ standing ☐ sitting ☐ sleeping ☐ Other:

Have you ever been treated for this condition in the past? ☐ Y ☐ N

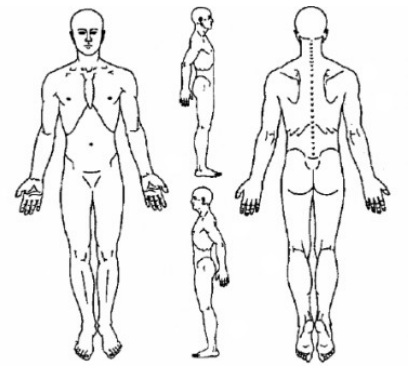
Please list any illnesses, injuries, surgeries, hospitalizations, or changes in your medical status since your last visit:

Please list any prescription & over the counter medications you are currently taking:

DO YOU HAVE INSURANCE? ☐ Y ☐ N Company: Policy Group Number:

ID Number: Cardholder's Name: SSN: DOB:

PAIN DIAGRAM: Please mark the location(s) of your pain on the figures below:



I understand and agree that health and accident insurance policies are an arrangement between the insurance company and myself. Furthermore, I understand that this office will submit charges, reports and forms to assist in the collection from the insurance company, and I understand that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse co–issued remittances for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment.

Patient Signature: **Date:**

Patient Name: _____

1. In general, would you say your health is: (choose one)

(1) ☐ Excellent (2) ☐ Very Good (3) ☐ Good (4) ☐ Fair (5) ☐ Poor

2. Compared to one year ago, how would your rate your health in general now? (choose one)

(1) ☐ Much better now than one year ago
(2) ☐ Somewhat better now than one year ago
(3) ☐ About the same
(4) ☐ Somewhat worse now than one year ago
(5) ☐ Much worse now than one year ago

The following items are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?

3. Vigorous activities, such as running, lifting heavy objects, participating in strenuous sports:
(1) ☐ Yes, limited a lot (2) ☐ Yes, limited a little (3) ☐ No, not limited at all

4. Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf:
(1) ☐ Yes, limited a lot (2) ☐ Yes, limited a little (3) ☐ No, not limited at all

5. Lifting or carrying groceries:
(1) ☐ Yes, limited a lot (2) ☐ Yes, limited a little (3) ☐ No, not limited at all

6. Climbing several flights of stairs:
(1) ☐ Yes, limited a lot (2) ☐ Yes, limited a little (3) ☐ No, not limited at all

7. Climbing one flight of stairs:
(1) ☐ Yes, limited a lot (2) ☐ Yes, limited a little (3) ☐ No, not limited at all

8. Bending, kneeling, or stooping:
(1) ☐ Yes, limited a lot (2) ☐ Yes, limited a little (3) ☐ No, not limited at all

9. Walking more than a mile:
(1) ☐ Yes, limited a lot (2) ☐ Yes, limited a little (3) ☐ No, not limited at all

10. Walking several blocks:
(1) ☐ Yes, limited a lot (2) ☐ Yes, limited a little (3) ☐ No, not limited at all

11. Walking one block:
(1) ☐ Yes, limited a lot (2) ☐ Yes, limited a little (3) ☐ No, not limited at all

12. Bathing or dressing yourself:
(1) ☐ Yes, limited a lot (2) ☐ Yes, limited a little (3) ☐ No, not limited at all

During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

13. Cut down the amount of time you spent on work or other activities: (1) ☐ Yes (2) ☐ No

14. Accomplished less than you would like: (1) ☐ Yes (2) ☐ No

15. Were limited in the kind of work or other activities: (1) ☐ Yes (2) ☐ No

16. Had difficulty performing the work or other activities (took extra effort): (1) ☐ Yes (2) ☐ No

During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?

17. Cut down the amount of time you spent on work or other activities: (1) ☐ Yes (2) ☐ No
18. Accomplished less than you would like: (1) ☐ Yes (2) ☐ No
19. Didn't do work or other activities as carefully as usual: (1) ☐ Yes (2) ☐ No

20. During the past 4 weeks, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbors, or groups?

(1) ☐ Not at all (2) ☐ Slightly (3) ☐ Moderately (4) ☐ Quite a bit (5) ☐ Extremely

21. How much bodily pain have you had during the past 4 weeks?

(1) ☐ None (2) ☐ Very mild (3) ☐ Mild (4) ☐ Moderate (5) ☐ Severe (6) ☐ Very Severe

22. During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?

(1) ☐ Not at all (2) ☐ Slightly (3) ☐ Moderately (4) ☐ Quite a bit (5) ☐ Extremely

These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling.

How much of the time during the past 4 weeks... (choose one number on each line)

	All of the time	Most of the time	A good bit of the time	Some of the time	Little of the time	None of the time
23. Did you feel full of pep?	(1) ☐	(2) ☐	(3) ☐	(4) ☐	(5) ☐	(6) ☐
24. Have you been a very nervous person?	(1) ☐	(2) ☐	(3) ☐	(4) ☐	(5) ☐	(6) ☐
25. Have you felt so down in the dumps that nothing could cheer you up?	(1) ☐	(2) ☐	(3) ☐	(4) ☐	(5) ☐	(6) ☐
26. Have you felt calm and peaceful?	(1) ☐	(2) ☐	(3) ☐	(4) ☐	(5) ☐	(6) ☐
27. Did you have a lot of energy?	(1) ☐	(2) ☐	(3) ☐	(4) ☐	(5) ☐	(6) ☐
28. Have you felt downhearted and blue?	(1) ☐	(2) ☐	(3) ☐	(4) ☐	(5) ☐	(6) ☐
29. Did you feel worn out?	(1) ☐	(2) ☐	(3) ☐	(4) ☐	(5) ☐	(6) ☐
30. Have you been a happy person?	(1) ☐	(2) ☐	(3) ☐	(4) ☐	(5) ☐	(6) ☐
31. Did you feel tired?	(1) ☐	(2) ☐	(3) ☐	(4) ☐	(5) ☐	(6) ☐

32. During the past 4 weeks, how much of the time has your physical health or emotional health problems interfered with your social activities (visiting with friends, relatives, etc.)?

(1) ☐ All of the time (2) ☐ Most of the time (3) ☐ Some of the time (4) ☐ A little of the time (5) ☐ None of the time

How TRUE or FALSE is each of the following statements for you?

	Definitely true	Mostly true	Don't Know	Mostly false	Definitely false
33. I seem to get sick a little easier than other people.	(1) ☐	(2) ☐	(3) ☐	(4) ☐	(5) ☐
34. I am as healthy as anybody I know.	(1) ☐	(2) ☐	(3) ☐	(4) ☐	(5) ☐
35. I expect my health to get worse.	(1) ☐	(2) ☐	(3) ☐	(4) ☐	(5) ☐
36. My health is excellent.	(1) ☐	(2) ☐	(3) ☐	(4) ☐	(5) ☐

Patient Signature: Date:

Alternative Health Care Center of the Black Hills

ELECTRONIC HEALTH RECORDS INTAKE FORM

In compliance with requirements for the government EHR incentive program

First Name: _____ Last Name: _____

Email Address: _____

Preferred method of communication for patient reminders (circle one): Email / Phone / Mail

DOB: ____/____/____ Gender (circle one): Male / Female Preferred Language: _____

Smoking Status (circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

CMS REQUIRES PROVIDERS TO REPORT BOTH RACE AND ETHNICITY

Race (circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian)
Native Hawaiian or Pacific Islander / Other / I Decline to Answer

Ethnicity (circle one): Hispanic or Latino / Asian / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medication? (Please include regularly used over the counter medications)

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

☐ I choose to decline receipt of my clinical summary after every visit *(These summaries are often blank as a result of the nature and frequency of chiropractic care).*

Patient Signature: _____ Date: _____

For office use only:

Height: _____ Weight: _____ Blood Pressure: _____ / _____

NOTICE OF PRIVACY PRACTICES (HIPAA) FORM

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION MAY BE USED AND DISCLOSED. PLEASE REVIEW IT CAREFULLY.

Alternative Health Care Center (AHCC) is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide patients with notice of legal duties and privacy practices with respect to your protected health information.

DISCLOSURE OF YOUR HEALTH CARE INFORMATION

TREATMENT: We may disclose your health information to other health care professionals within our practice for the purpose of treatment, payment or health care operations. It may be necessary to seek consultation regarding your condition from other health care providers associated with AHCC. Substitute health care providers within AHCC may provide treatment to our patients in the event of your primary health care provider's absence due to vacation, sickness or other emergency situations.

PAYMENT: We may disclose your health information to your insurance provider for the purpose of payment or health care operations. As a courtesy to our patients, we will submit an itemized billing statement to your insurance carrier for the purpose of payment to AHCC for health care services rendered. The billing statement contains medical information such as diagnosis, date of injury or condition and codes which describe the health care services received.

WORKERS' COMPENSATION: We may disclose your health information in order to comply with State Workers' Compensation Laws.

EMERGENCIES OR DECEASED PERSONS: We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death. We may disclose your health information to coroners or medical examiners.

PUBLIC HEALTH & SAFETY: As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the FDA problems with products and reactions to medications, reporting disease or infection exposure, and preventing or lessening a serious threat to the health or safety of a particular person or to the general public.

JUDICIAL & ADMINISTRATIVE PROCEEDINGS: We may disclose your health information in administrative or judicial proceedings.

LAW ENFORCEMENT & SPECIALIZED GOVERNMENT AGENCIES: We may disclose your health information to law enforcement officials for purposes such as identifying/locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena and other law enforcement purposes, or for military, national security, prisoner and government benefits purposes.

CHANGE OF OWNERSHIP: In the event that AHCC is sold, your health information will become the property of the new owner.

YOUR HEALTH INFORMATION RIGHTS: You have the right to: request restrictions on certain uses and disclosures of your health information (however, AHCC is not required to agree to the restriction(s) that you request); inspect and copy your health information; request that AHCC amend your protected health information (however, AHCC is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and how you can disagree with the denial); request a paper copy of this Notice of Privacy Practices at any time upon request.

CHANGES TO THIS NOTICE OF PRIVACY PRACTICES: AHCC reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, AHCC is required by law to comply with this Notice. AHCC is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information.

I HAVE READ THE PRIVACY NOTICE AND UNDERSTAND MY RIGHTS CONTAINED IN THE NOTICE: By way of my signature, I provide AHCC with my authorization and consent to use and disclose my protected health care information as described in the Privacy Notice.

I authorize AHCC to use/disclose health information about me to (family member/friend): _____

Patient's Printed Name: _____

Patient's Signature _____ **Date:** _____

ALTERNATIVE HEALTH CARE CENTER INFORMED CONSENT FORM

Dear Patient:

Every type of health care is associated with some risk of a potential problem. This includes Chiropractic health care. We want you to be informed about potential problems associated with Chiropractic health care before consenting to treatment. This is called informed consent.

Chiropractic adjustments are the moving of bones with the doctor's hands or with the use of a tool. Usually those movements result in a "pop" or "click" sound and/or sensation in the area being adjusted.

In this office we may use trained staff personnel to assist the doctor with portions of your consultation, physical examination, x-rays, traction, exercise instruction, or other services. Occasionally, when your doctor is unavailable, another doctor will be available to adjust you on that day.

STROKE: Stroke is the most serious potential problem associated with Chiropractic adjustments. Stroke means that a portion of the brain does not receive enough oxygen for the bloodstream. The result can be temporary or permanent dysfunction of the brain, or even death. Chiropractic adjustments have been associated with strokes that arise from the vertebral artery only. This is because the vertebral artery is actually found inside the neck vertebrae. The adjustment that is related to the vertebral artery stroke is called the "Extension-rotation thrust atlas adjustment". Fortunately, we do not perform 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. The most recent studies (Journal of the CCA. Vol. 37. No. 2 June, 1993) estimate that the incident of this type of stroke is 1 per every 3,000,000 upper neck adjustments. This means that an average Chiropractor would have to be in practice for hundreds of years before he or she would statistically be associated with a single patient stroke.

SOFT TISSUE INJURY: Soft tissues primarily refer to muscles and ligaments. Muscles move bones and ligaments limit joint movement. Rarely a chiropractic adjustment, traction and/ or therapeutic exercise may damage some muscle or ligament fibers. The result is a temporary increase in pain which may necessitate extra visits for resolution, but there are no long-term effects for the patient. These problems occur so rarely that there are no available statistics to quantify their probability.

RIB FRACTURES: The ribs are found only in the thoracic spine or middle back. They extend from your back to your front chest area. Rarely a chiropractic adjustments will crack a rib bone, and this is referred to as a fracture. This occurs only in patients who have weakened bones from such things as osteoporosis. Osteoporosis can be noted on your x-rays. We adjust all patients very carefully, and especially those who have osteoporosis on their x-rays. These problems occur so rarely that there are no available statistics to quantify their probability.

SORENESS: It is common for Chiropractic adjustments, traction and or/ therapeutic exercise to result in an 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 and may vary according to your general health.

OTHER PROBLEMS: There may be other problems or complications that can arise form Chiropractic care other than those noted above. These 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 health care delivery, and therefore, as with any health care delivery system, we cannot promise a cure for any symptom, disease or condition as a result of treatment in this office. We will always give you our best care, and if results are not acceptable, we will refer you to another provider who may be better able to fulfill your needs.

If you have any questions of the above, please ask your doctor. When you have full understanding, please sign and date below.

Patient's Printed Name: _____

Patient's Signature _____ **Date:** _____

Alternative Health Care Center of the Black Hills

OUR SERVICES:

The methods of care employed by the practitioners and staff at this clinic may involve any or all of the following:

- *Case history*
- *Sensory, muscle & reflex testing*
- *Physical exam*
- *Allergy testing*
- *Acupuncture*
- *Meridian stress assessment*
- *X–rays*
- *Special instrumentation*
- *Hair analysis*
- *Nutritional & dietary programs*
- *Bio–photon*
- *Interferential*
- *Whole body / spinal exercises*
- *Detoxifying foot bath*
- *Emotional exercises*
- *Blood testing*
- *Mechanical traction*

FEES:

We offer a few different methods of payment to make your journey to wellness as convenient as possible. We discuss these payment options with you at you Report of Findings visit. We accept cash, check, credit and debit.

INSURANCE:

We file a claim to your insurance company as a courtesy to you. Only one visit per day will be submitted; however, you are responsible for any co–payment and deductible amounts at the time of service, unless previously arranged. You will also be responsible for any services that are not covered by your insurance company, unless previously arranged. Payment options and arrangements may be discussed at any time; however, it is best to let us know in advance so we can get account information accessible.

If you have any questions of the above, please ask your doctor. When you have full understanding, please sign and date below.

Patient's Printed Name: _____

Patient's Signature _____ **Date:** _____