Date: _____

Name: _____ Email: _____

Address: _____ City: _____ Zip: _____ Phone#:_____

Birth date: _____ Sex: _____ Age: _____ Marital Status: _____ # of Children_____

Occupation: _____ Employer: _____ Work Phone#:_____

Social Security Number:_____ How did you hear about our office? _____

PLEASE FILL IN THE APPROPRIATE SPACES (All information you give is confidential)

MAJOR COMPLAINT_____

_____

How long have you had this condition? _____

Date Began:_____

Have you lost work days? □ Yes □ No How Many? _____

Have you had this similar before? □ Yes □ No When? _____

Was The Injury related to: □ Work accident □ Auto Accident

When did you last see a chiropractor_____ Dr.: _____

Why did you see this chiropractor? _____ Were you helped? _____

What spinal maintenance programs were you given to follow, to maximize the future stability of your spine?_____

Did you follow it? □ Yes □ No If not why?_____

Why are you changing chiropractors? _____

PAST (O) OR PRESENT (X) CONDITIONS:

___ Fractured Bones
___ Auto Accidents
  a. ___ 0-1 years ago
  b. ___1-5 years ago
  c. ___More than 5 years ago
___ Other Accidents/Falls
___ Knocked Unconscious
___ Back Curvature
___ Mental or Emotional Disorders
___ Arthritis
___ Diabetes
___ Swollen or Painful Joints
___ Convulsions/ Epilepsy
___ Skin Problems
___ Itching
___ Bruise Easily
___ Cancer
___ Frequent Colds/Flu
___ Nervousness
___Tension
___ Depressed
___ Irritable
___Anemia
___Excess Sweating
___Tremors
___ Light Bothers Eyes
___Allergy
___ Sinus Problems
___Light Headed Upon Rising
___ Under Stress
___ Crave Sweets or Salt
___ Eating Disorders
___ Trouble Sleeping
___ Trouble Concentrating
___ Loss of Memory

___Learning Disability
___ Mistake Sidedness (Rt. from Lt.)
___ Stutter
___ Dyslexia
___ Mood Changes
___ Lose Temper Easily
___ Headache
___ Neck Pain or Stiff R. L.
___ Numbness, Tingling, or Pain in arms, hands or fingers
___ Jaw Pain or Click (T.M.J.) R. L.
___Head seems too heavy
___ Head & Shoulders feel tired
___Difficulty in excessive (standing, walking, sitting riding, bending, lifting, twisting, household duties)
___ Shoulder pain R. L.
___ Dizziness
___ Ringing in ears R. L.
___ Hearing loss R. L.
___Fainting
___Loss of balance
___ Blurred or double vision R. L.
___ Upper back pain or stiffness R. L.
___ Mid back pain or stiffness R. L.
___ Lower back pain or stiffness R. L.
___ Numbness, tingling or pain in buttocks, thighs, legs, feet toes R. L.
___Pain with cough, sneeze or strain at stools
___Hip pain R. L.
___ Foot trouble R. L.
___Chest pain

___ Asthma
___Difficulty breathing
___ Lung Problems
___ Wheezing
___ Heart problems
___Stroke
___ High or Low blood pressure
___Varicose veins
___Liver trouble
___ Gall Bladder trouble
___Digestive problems
___ Excessive gas
___Belching/bloating after meals
___ Heartburn
___ Ulcers
___Diarrhea/ constipation
___ Colon trouble
___ Hemorrhoids
___ Prostate problems
___Impotence
___ Kidney trouble
___Kidney stones
___ Frequent urination
___ Discharge
___ Menstrual problems/PMS
___Menopausal problems
___ Breast lumps, soreness, discharge
___ Pregnant (currently)
___ Bed wetting
___ Ear infections
___Hepatitis
___Venereal disease
___AIDS/HIV
Other_____

Doctor Use

Cerv. Flex/Ext ___
Cerv. Rotation ___
Cerv. Lat. Flex ___
F. Comp. L/R ___
Max Cerv. Compress L/R ___
Cerv. Dist. ___
Soto Hall ___
Adson's ___
Mod. Adson's L/R ___
Scalene L/R ___
Grip Test L/R ___
Lumb. Flex/Ext ___
Lumb. Rotation ___
Lumb. Lat. Flex ___
Dejerine ___
Bechterew L/R ___
Belt's Test ___
Braggard's L/R ___
Yoman's Test L/R ___
Ely's Test L/R ___
Kemp Test L/R ___
Patrick Fabere L/R ___
S.L.R L/R ___
C _____
T _____
L _____
S _____

ASPEN RIDGE CHIROPRACTIC

WHAT IS YOUR HEALTH PHILOSOPHY? (What should you do to be healthy?)_____
_____
_____

HOW DO YOU WANT US TO HANDLE YOUR PROBLEM?

_____ Temporary Relief (Help the symptom but not necessarily fix the cause of the problem)
_____ Maximum Correction (Correct the cause of the problem for maximum stability in the future)

WHY DID YOU COME INTO OUR CLINIC AND WHAT ARE YOUR EXPECTATIONS OF US? _____
_____

1. What are your favorite activities or hobbies to do now? _____
2. Are your current problems affecting these activities or hobbies? _____
3. What activities are you looking forward to doing in retirement? _____
4. Who would you like to be doing these with? _____

On a scale of 1-10 (10 being the most, and 1 being the least).

_____ How committed are you at being at your maximum health potential?
_____ How important is it for your family to be at their maximum health potential?
_____ How committed are you to preventing arthritis and maximizing your spinal stability?

What surgeries have you had? _____
List drugs you now take (prescription & non-prescription) _____
_____
Name other doctors you have seen for this condition, what was done, and for how long?
_____
_____
Are you currently wearing ☐ Heel Lifts ☐ Arch Supports ☐ Foot Orthotics

_____

PLEASE FEEL FREE TO DISCUSS OUR FEES. FEES ARE PAYABLE WHEN SERVICES ARE RECEIVED UNLESS SPECIAL ARRANGEMENTS ARE MADE IN ADVANCE.

_____

_____
_____
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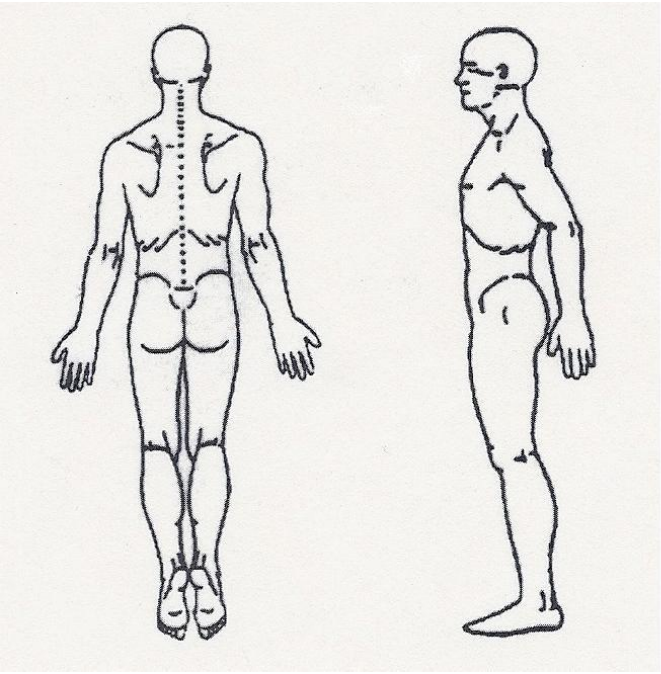
Please mark your areas of concern on the figures below



Signature_____

WELCOME TO OUR OFFICE

We are committed to providing you the best care and are pleased to discuss our professional fees with you at anytime. Your clear understanding of our financial policy is important to our professional relationship. Please ask any questions you may have regarding our fees in complying with our financial policy and/or procedures. The best health services are based on a friendly, mutual understanding between you and your doctor.

CASH PATIENTS: Payment is due when services are rendered. We gladly accept Mastercard, Visa, check or cash.

INSURANCE PATIENTS: Professional services are rendered and charged to your insurance on your behalf. Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made. Any services not covered by your insurance are ultimately your responsibility and may have to be paid by you at the time of service. If you fail to keep your scheduled appointments or if you discontinue care for any reason other than discharge by the doctor, the bill is due and payable by you in full immediately, regardless of any insurance claim submitted. In certain cases our office accepts billing for individual or group insurance policies, personal injury claims, authorized worker's compensation and Medicare.

DISCLOSURE OF INFORMATION: If your insurance company should send a check to you that cover services rendered in this office, you agree to deliver that check, and any associated paperwork, to this office within (1) one week of receipt. You hereby authorize assignment of your insurance rights and benefits directly to your provider for service rendered. You authorize the staff to perform any necessary services during diagnosis and treatment.

If this was the result of a motor vehicle accident: Your health insurance may not cover specific treatments that may be beneficial in your case. We reserve the right to collect our usual and customary fees for services rendered during your treatment in our office. We also reserve the right to bill any and all insurance carriers that may be responsible for provided coverage.

Authorization to Process Drafts: I agree that Aspen Ridge Chiropractic P.C. shall be appointed as my agent to endorse drafts on any checks for payment of my bill for medical services rendered.

Limited Release of Medical Information: I authorize Aspen Ridge Chiropractic P.C to make inquires and to release any pertinent information to any insurance company, government agency, adjuster or attorney to facilitate collection under these assignments.

Assignment of Cause of Action: In the event that any insurance company or third party obligated to make payment to me or to Aspen Ridge Chiropractic P.C for the charges made for the services, refuses to make such payment upon demand, I hereby assign, transfer, and convey to Aspen Ridge Chiropractic P.C any and all cause of action that might exist in my favor against any such company or person. I authorize Aspen Ridge Chiropractic P.C to prosecute said action in my name or their name to collect fees due for care rendered and legal expenses, and to resolve said claims as they see fit.

Patient Printed Name: _____

Patient Signature: _____ Date: _____
(if patient is under 18 years of age, legal guardian must sign above)

Witness: _____ Date: _____

It is the Patient's responsibility to inform our office of any changes in your medical or insurance status.

ASPEN RIDGE
CHIROPRACTIC

Notice of Privacy Practices

This summary discloses how health information about you may be used. A full notice of Privacy rights has also been provided to you.

Aspen Ridge Chiropractic P.C. uses health information about you for treatment, to obtain payment for treatment with your authorization, for administrative purposes, and to evaluate the quality of care that you receive.

Aspen Ridge Chiropractic P.C. will not disclose your information to others unless you tell us to do so, or unless the law authorizes or requires us to do so.

Aspen Ridge Chiropractic P.C. may use your information to provide appointment reminders, information about treatment alternatives or other health-related issues.

Aspen Ridge Chiropractic P.C. may disclose your information for public health activities, to funeral directors to enable them to carry out their activities, for organ and tissue donations, research, health and safety, government function in order to comply with workers compensation laws and regulations.

Aspen Ridge Chiropractic P.C. has the right to adjust your spine in an open adjusting room where other patients are also present. You acknowledge that the doctor will be talking to you about your case openly in each visit as he adjusts you and other people may hear information about your particular case. Should you request privacy regarding anything to do with your case, you will request it with the staff or doctor and will be placed in a private adjusting room or consultation room.

You have a right to request restriction, report and retain a copy of your health record, request communication of your information by alternative means at alternative locations, revoke your authorization and request an accounting of your health records. You may complain to the Privacy Officer and to the Department of Health and Human Services if you believe your rights have been violated. You will not be retaliated against for filing a complaint.

Aspen Ridge Chiropractic P.C. must maintain the privacy of protected health information, provide you with notice of its legal duties an privacy practices with respect to your health information, abide by the terms of the notice, notify you if it was unable to agree to the requested restriction on how your information is used or disclosed, accommodate reasonable requests you may make to communicate with health information by alternative means or by alternative location and obtain your written authorization to use or disclose your health information for reasons other than those listed above and permitted under law.

If you have any questions or concerns, please contact our office at 208-552-8866.

Patient Printed Name: _____

Patient Signature: _____ Date: _____
(if patient is under 18 years of age, legal guardian must sign above)

Witness: _____ Date: _____

ASPEN RIDGE
CHIROPRACTIC

Informed Consent to Chiropractic Treatment

The following is Aspen Ridge Chiropractic's informed consent for treatment. We intend this consent form to cover the entire course of treatment for your present condition and for any conditions for which you seek treatment at this clinic.

The nature of chiropractic treatment: The doctor will use his/her hands or a mechanical device in order to adjust/manipulate your joints. You may hear a "click" or "pop", similar to when a knuckle is "cracked" and you may feel movement of the joint. Various ancillary procedures, such as a hot or cold packs, electric muscle stimulation, mechanical traction, as well as exercise instruction may also be used.

Possible risks and probability: There are inherent risks in my and all treatment derived by any health care provider ranging from taking a single aspirin to a complicated brain surgery. Chiropractic care is no exception. Although we take every precaution, there are indeed some slight risks to chiropractic adjustments/manipulations. The risk is very minor in any treatment of the extremities. The risks involved in treatment to the spine while rare are as still possible. A list from the least to the most serious would include muscular strain (rare), ligamentous sprain (rare), fractures (rare), and injury to the intervertebral discs, nerves, or spinal cord (very rare). There is the remote possibility of stroke (extremely rare) with adjustments in the neck. A minority of patients may notice a stiffness or soreness after the first few days of treatment (common). The ancillary physical therapy procedures could produce skin irritations, burns or other minor complications (rare).

Other treatment options, not provided by this clinic, which could be considered, may include the following: Over-the-counter analgesics. The risks of these medications include irritations to the stomach, liver and kidneys and other side effects in a significant number of cases. Medical care, typically anti-inflammatory drugs, tranquilizers and analgesics. Risks of these drugs include numerous undesirable effects, usually more serious than those listed above and patient dependence in a significant number of cases. Surgery in conjunction with medical care adds the risks of adverse reactions to anesthesia (which include death), as well as extended convalescent period in a significant number of cases.

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility and include chronic pain cycles.
It is quite probable the delay of treatment will complicate the condition, and make further rehabilitation more difficult.
Concerns or questions: Please ask your Doctor of Chiropractic, Dr. Miller and the staff at Aspen Ridge Chiropractic has gone to great lengths to make your health and safety a top priority. Dr. Miller will be glad to explain any concerns about treatment you may have. Suffice to say we will only recommend treatment for you that we would feel comfortable having performed on ourselves.

I have read the above explanation of chiropractic care. I also had the opportunity to ask questions and have them answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and hereby give my full consent to treatment.
I have read and understand the above and I give my consent to undergo spinal adjustments at Aspen Ridge Chiropractic P.C.

Patient Printed Name: _____

Patient Signature: _____ Date: _____
(if patient is under 18 years of age, legal guardian must sign above)

Witness: _____ Date: _____

ASPEN RIDGE
CHIROPRACTIC

Consent for Purposes of Treatment, Payment and Health Care Operations

I consent to the use or disclosure of my protected health information by Aspen Ridge Chiropractic P.C. for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills, or to conduct health care operations.

I understand that my diagnosis or treatment by Aspen Ridge Chiropractic P.C. may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or health care operations of the practice. Aspen Ridge Chiropractic P.C. is not required to agree to the restrictions that I may request. However, if Aspen Ridge Chiropractic P.C. agrees to a restriction that I request, the restriction is binding. I have the right to revoke this consent, in writing, at any time, except to the extent that Aspen Ridge Chiropractic P.C. has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan , my employer or a healthcare clearing house. This protected health information relates to my past, present, or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review Aspen Ridge Chiropractic P.C. Notice of Privacy Practices prior to signing this document. Aspen Ridge Chiropractic P.C.'s Notice of privacy Practices have been provided to me.

The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Aspen Ridge Chiropractic P.C. This notice of Privacy Practices also describes my rights and the duties of Aspen Ridge Chiropractic P.C. with respect to my protected health information.

Aspen Ridge Chiropractic P.C. reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy to be sent in the mail or asking for one at the time of my next appointment

Notice of Privacy Practices - Acknowledgment

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting Aspen Ridge Chiropractic P.C..

Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed, and you can access your information. ***By my signature below I acknowledge receipt of the Notice of Privacy Practices.***

Patient Printed Name: _____

Patient Signature: _____ Date: _____
(if patient is under 18 years of age, legal guardian must sign above)

Witness: _____ Date: _____

This form will be retained in your health record

ASPEN RIDGE
CHIROPRACTIC